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The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

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Curity
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Across the Desk

By C. A. E.

Increased Interest in Occupational Therapy

THE Occupational Therapy Course at the University of Toronto is becoming increasingly popular, due to the demands of the armed services for occupational therapists.

While the second year enrolment of approximately 40 is of about normal size as compared with recent years, the First Year (term starts in September) has exceeded all previous records with an enrolment of 98 students.

The use of the term "therapeutic occupations" in place of "crafts" in the curriculum indicates that the basic approach to the subject is medical, and not on the development of craftsmen.

* * * *

Voluntary Hospitals Lead

It is generally agreed, in medical and hospital circles, that the voluntary hospitals are chiefly responsible for the many improvements in medical procedures and hospital administration. There are, of course, many municipal and other government institutions which equal and sometimes outrank the voluntary hospitals in this respect. But it is natural that research money and other philanthropic gifts should go to the voluntary group. Few enjoy giving money to the government, unfortunately. Americans are known for their philanthropy—for their desire to be their brother's keeper.

We, in hospitals, find this good; results speak for themselves. We are the best cared for people in the world, despite lack of medical and hospital care to isolated, sparsely settled districts in some of the States. We think this humane system has proved its worth, and we would like to see it continued.—John H. Hayes, in *Hospitals.*

* * * *

Scientific Hospital Lighting

Lighting can be good, bad or indifferent. Good lighting increase the ease and speed of seeing and favours safe aseptic operation, which is so essential in hospitals, from the surgery to the laundry. Good lighting is also economical lighting, but to be economical it must be controlled and not allowed to dissipate wastefully.

The Holophane Company Limited, Toronto, have long been known in the hospital field as experts in institutional lighting. Their new catalogue treats in detail with efficient lighting for every department in the hospital. The Administrator will find that it contains information designed to overcome poor lighting problems, some of which may have been considered "incurable".

You are invited to write for a copy of "Lighting for the Hospital of To-day".

* * * *

Drives Should Continue After V-Day

The War Advertising Council in the United States, following completion of a survey of home-front information programmes in co-operation with the Office of War Information, has announced that continued public support for a score of the more important ones will be essential after the end of the war in Europe in order to insure

Closure of the Dura following Brain Surgery

Stitches readily and quickly placed with new (smaller) model A-11 Singer Surgical Stitching Instrument. Note absence of loose ends and complete visibility of suture area.

The new A-11 Model, designed especially for use in delicate surgery.

Just the right stitch—

PLACED FASTER AND EASIER

Extended use by outstanding surgeons—in operative work on the brain, for example—has shown the greater facility with which sutures may be placed by means of the Singer Surgical Stitching Instrument, and the considerable time it helps to save.

Indeed, for all surgical work, this ingenious suturing instrument (available in both "standard" size, and the smaller "A-11" model) affords almost unlimited versatility to suit the particular stitch requirements of each case. It utilizes needles from the smallest practicable in surgery to the largest—employs any suturing material (which it feeds from a continuous spool supply) and need not leave the surgeon's hand during the entire suturing phase.

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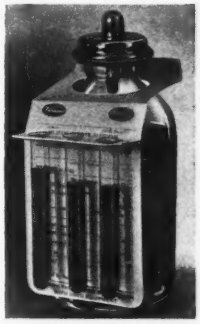

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243 BROADWAY **CAMBRIDGE, MASSACHUSETTS**

the "speediest possible victory over Japan and an easier adjustment to peace".

The study indicates that of thirty-two major current information campaigns, seventeen will require continuation for at least six months after victory in Europe. These include accident prevention and safety; Red Cross: cadet nurses; economic stabilization; food price ceilings; forest fire prevention; gasoline black markets; National War Fund; nutrition; paper salvage; planned spending and saving; venereal diseases; V-mail and war bonds.

* * * * —*Marketing.*

Sharp & Dohme Celebrates 100th Anniversary

This year Sharp & Dohme is celebrating its 100th anniversary. The history of this great organization, which is now so well and favorably known to the drug trade in all quarters of the globe, speaks volumes for the foresight and industry of the early founders of the business.

Recognizing the importance of research, Sharp & Dohme maintain a large well-trained technical staff devoting their entire time and attention to research. The Research Laboratories are housed in a new building equipped with all the modern devices for carrying on this important work. It was in these laboratories that they pioneered in the synthesis and study of Sulfadiazine and Sulfamerazine and also developed "Sulfasuxidine", "Sulfathalidine", "Propadrine", "Hydrochloride", the family of hexylresorcinol products and the popular and outstanding sedative and hypnotic "Delvinal" Sodium.

In addition to these outstanding products, this research group also developed the process of lyophilizing biological products, particularly dried blood plasma which has been one of the most important single factors in reducing mortality in our armed forces.

Distribution of Sharp & Dohme products is now well established throughout the world. Branches are located in twenty-two leading cities in the United States and in many countries, and subsidiary companies are operating in England, Mexico, and South America.

In Canada, the sale of Sharp & Dohme products was carried on through sales agents for many years, but in 1940 Sharp & Dohme (Canada) Ltd., was established. Manufacturing and distribution are now centralized at Toronto. Growth has been constant and rapid, the amount of floor space having been increased to three times the space originally occupied in order to take care of the larger volume of business.

* * * *

"Wired" Music Available

Tele-Muse Corporation Limited, Toronto, is a new company organized to furnish "wired" music to subscribers. From a central broadcasting studio, this company transmits music to hospitals, industrial plants, and other establishments.

The programmed music is scientifically planned to produce a desired, predictable effect on listeners, and is carefully chosen to fit the needs of subscribers. Several programmes are sent out simultaneously, so that a subscriber in any one of six different kinds of business or calling may have the type of music best suited to his particular situation.

Operay Multibeam

FOR DEEP AND LATERAL CAVITY ILLUMINATION

Deep-cavity surgical techniques require deep-cavity illumination. Surface illumination is not enough. The Operay Multibeam supplies cool, glareless, powerful illumination that floods the operating area. Projection may be angled to light deep and lateral surgical cavities.

Surg-O-Ray Portable

FOR FLEXIBLE SURGICAL ILLUMINATION

Excellent surgical illumination, combined with easy portability and convenient adjustability, make the Surg-O-Ray Portable an effective adjunct to the basic surgical equipment of the hospital. Produces flood illumination on an 8" diameter area or high intensity illumination on a 4" spot. Available also in ceiling types.

Send for catalogs of Surgical Tables and Lights, Surgical Sterilizers, Bedpan Apparatus, Surgical Furniture, Delivery Tables, Infant Equipment, Surgical Sutures.

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Manufacturers of

Sterilizing Apparatus
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Operay Surgical Lights
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Across The Desk

New Fluorescent Fixture

A new fluorescent fixture to accommodate 2-40 watt fluorescent lamps has been announced by Canadian General Electric Co., Ltd.

These fluorescent fixtures are engineered to RLM Standards specifications. The light source is adequately shielded by the reflector which has a 13 degree shielding angle from the horizontal. The lamps are spaced on 5 inch centres in accordance with RLM specifications. All auxiliary equipment is mounted in the sheet steel cover

for ease of installation and maintenance. Dieformed platforms of 18-gauge steel and cast aluminum end plates ensure rigid, accurate mounting of sockets. The one-piece steel reflector is easily detached from the cover by two wing nuts which provide positive, anti-vibration locking of reflector. To eliminate chipping of enamel, the lamp-holder openings in the reflector are designed with rounded corners, free from narrow brittle sections. The edges of the reflector are double-folded for greater strength.

The reflectors are available with either porcelain enamel or baked synthetic enamel finish inside and out. The reflection factor; porcelain enamel 79%; baked enamel 89%. The outside of the reflector and cover is finished in light grey.

* * * *

Music As Therapy

How many mental hospitals use music as therapy? To find out, the National Music Council recently "quizzed" 209 institutions. Of this number, 192 did use music, though only 23 reported using it for therapeutic reasons, while 134 used it for both recreation and therapy. There were performances in 160 hospitals by gifted patients, guest artists, choirs, bands and glee clubs, while 152 institutions used recorded music.

The institutions which did not use music, it is interesting to note, were prevented from doing so because of shortage of personnel, lack of funds or facilities.—*Hospital Topics and Buyer.*

* * * *

H-u-s-h, the Gestapo!

Three managers of chicken farms in Germany were being questioned by a gestapo man. "What do you feed your chickens?" the first was asked.

"Corn."

"You're under arrest! We use corn to feed the people."

The second manager overheard the conversation, and tried to play safe.

"What do you feed your chickens?" came the question.

"Corn husks."

"You're under arrest! We use the husks to make cloth."

"And you?" he asked, turning to the third man.

"I give my chickens the money and tell them to go and buy their own food."

ANTISEPSIS

The Test of Experience

'The destruction of bacteria (disinfection) or 'interference with their activities (antisepsis) by 'chemical means is attempted daily in pro- 'ceedings ranging between proved usefulness and 'utter futility. The value of such proceedings 'must be judged ultimately by their clinical 'results, but in devising or making a choice 'between them when such results are equivocal, 'theoretical considerations must be given 'weight.' ✲

'Dettol' has been increasingly used for over ten years throughout the British Empire—in general hospitals, maternity homes, factories, schools and households. It has been put to test in all the contingencies that call for the use of an antiseptic—and under every conceivable condition, from the planned operation quietly and unhurriedly performed in the modern operating theatre to the pressing emergency treated against time in the field casualty station. The experience has been long enough and varied enough to define its scope and limitations, to test its strength and expose any fundamental weaknesses.

It is not without significance that in this period 'Dettol', which first came into use as the routine antiseptic in obstetric practice, has become the most widely used general-purposes antiseptic in the Empire. Obstetricians were particularly influenced by its complete and certain bactericidal action on the hæmolytic streptococci responsible for the great majority of puerperal infections; and by its capacity to form a durable barrier against re-infection by these organisms. Surgeons were not slow to see the possibilities of an antiseptic which combined high bactericidal power—even in the presence of blood, pus and wound contaminants—with complete non-toxicity; which could in short be used, safely and effectively, on the skin, in the wound and for instruments. The general public was influenced by less weighty considerations: by the fact that its application, whether to wounds, abraded surfaces or mucous membranes, did not cause pain; that it did not stain or injure linen; and that, unlike poisonous antiseptics, it could be left in an accessible place for the use of the whole household.

Thus, the testimony of the laboratory and of the controlled clinical investigation has been borne out and strengthened by the test of experience—vast, ever growing, and tending only to extend the range of conditions in which 'Dettol' is applied as the antiseptic of choice.

✲ *Garrod, L. P., and Keynes, G. L.* (1937). *Brit. med. J.* **2**, 1233

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DEPARTMENT, MONTREAL

M.62

Across The Desk

(Continued from page 20)

Plastic Artificial Eye is Custom Molded to Fit

A Canadian soldier who lost an eye at Dieppe is wearing an all-plastic artificial eye as a result of the ingenuity and efforts of a Montreal dental technician, Russell Copeman. The story of the making of such eyes is told by Elizabeth McKechnie in the current issue of C-I-L Oval.

It is easy to see why an artificial eye of plastic is more serviceable than one of glass. The wearer of a glass eye must beware of the ever-present hazard of breakage. There is always the possibility that temperature changes will cause a glass eye to crack or explode while it is being worn. When a glass eye is made to order, it cannot be molded to the shape of the individual socket. It can only be blown in the presence of the patient and though this ensures a better fit than would a stock eye, it is almost impossible to shape it to an exact fit. In order that the eye socket may retain it, it must be made oversize and frequently causes irritation and discomfort. Chemical reaction may cause discoloration.

On the other hand, the all-plastic eye is resistant to breakage. It is inert to temperature changes and chemical reaction. And because it can be molded to the shape of the individual socket, discomfort and irritation are eliminated, and the eye has greater freedom of movement.

From a wax impression of the socket of the eye, a plaster mold is made. Then two dies are made, an undersized one in which the eyeball is molded and a full-sized one in which the finished eye, complete with iris, pupil and cornea, is shaped.

The most difficult step is the coloring of the iris to match the patient's other eye. You might think your eyes are brown but you would be amazed at the variety of color that has to be used to duplicate your iris. You may have the faint suggestion of a blue rim around the outside. You may have a touch of red, a bit of yellow and some amber in your iris. Sometimes it is difficult to obtain the delicate shades with powdered dyes, so artists' paints are used instead, in minute quantities, and applied with a paintbrush. After each color is applied, a drop of the plastic in liquid form is added. The pupil is made smaller than it actually is, because the overlayer of colorless acrylic which is subsequently applied magnifies its size. When the coloring is complete, the colors are allowed to set and the eye is ready to receive the cornea, or transparent coat of the eyeball which covers the iris and the pupil.

* * * *

Support Your Red Cross Drive

"We *must* pass all quotas in the 1945 Campaign for funds. These many years of war, these years of sorrow and devastation have passed—and the end is not yet. Mrs. C. F. McEachren, Chairman of the National Women's War Work on her return from England so ably expressed the position of Canada in these words 'We in Canada are *at* war—the British people are *in* it.' Let us in gratitude for our good fortune *give more generously* than ever before—to those who have lost all but courage."—*Mrs. Arthur W. Ellis.*

Just pull

FOR ALL YO

On April 23rd the Eighth Victory Loa
will be in full swing. Naturally, as i
previous loans, you will purchase t
the very limit to make this loan
success. Your country asks you to d
more than that.

You exercise more weight than mo
men in your community and in the bus
ness and industrial life of the land. You

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Get ready to

YOU'RE WORTH—

position carries with it certain responsibilities too. You are asked to devote your full energy towards making this loan a success.

Your influence can be a powerful factor in organizing groups of employees to participate in this loan. You can help to make the loan a success in your own residential section. In your daily contacts, by word of mouth and by action, you can influence and inspire groups of people to push this loan quickly over its objective.

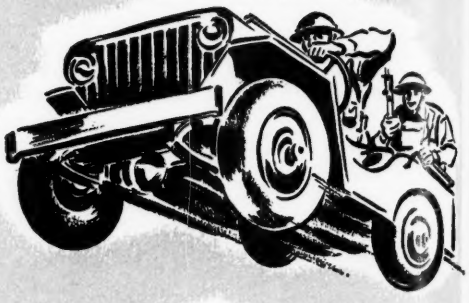
Your country needs men of your calibre to put energy and enthusiasm behind the organization of this loan. Take hold and—pull for all you're worth.

to Buy Victory Bonds

NATIONAL WAR FINANCE COMMITTEE

ALCOHOL

that BOUNCES



LOOK at the tires on that jeep. Today they're made of synthetic rubber, bouncing offspring of industrial alcohol. Thanks to the ingenuity of Canadian Distillers we shall never again be dependent on distant sources for our rubber.

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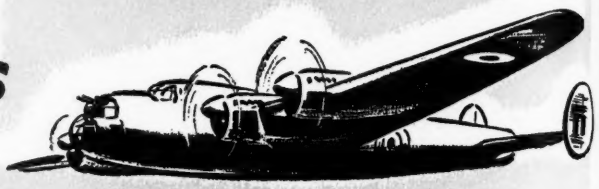

HIGH in the sky industrial alcohol flies with commercial and fighting aircraft—de-ices, protects. It is part of the powerful explosives that charge the Block Busters in the bomb bays.

that WORKS for YOU

INDUSTRIAL alcohol is a vital factor in the manufacture of thousands of products in a wide field of industry. Canadian Industrial Alcohol maintains a staff of qualified chemists who are available for consultation and collaboration in any of your problems. May we work with *you?*

A PRODUCT OF C I A

Maple Leaf Alcohols

CANADIAN INDUSTRIAL ALCOHOL COMPANY LIMITED

CORBYVILLE, ONT.

MONTREAL TORONTO WINNIPEG

A New ADMITTING PROCEDURE that pleases PATIENTS, DOCTORS and HOSPITAL PERSONNEL

A new and most satisfactory system has been adopted by one of the largest hospitals on the continent.

It is highly efficient. Involves *no* repetitious clerical work. No annoyance to patients. No delay and practically no possibility of error. This modern admitting procedure provides many important benefits. Among them are the following:

1. All questioning is completed in *one* interview.
2. Every record originates simultaneously in the Admitting Office.
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7. Admitting Office gains time for additional duties.
8. Time is saved for switchboard and information clerks as well as nurses.

Yet with all its advantages, this procedure is extremely simple. It requires *standard* equipment only . . . the Elliott Fisher Electric Writing Machine. It sacrifices *none* of the virtues of any existing system.

All the details of how to install it are yours for the asking. They are fully described in a booklet we shall be glad to send you. Write for your copy of "Centralized Control of Admitting Records", which explains this new system which saves so much time and man-power.

Mail the coupon at once for booklet containing full details.

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Please send a free copy of "Centralized Control of Admitting Records" to the undersigned.

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Hospital.....

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, March, 1945 Vol. 22 No. 3

Restrictions on Penicillin Distribution now Relaxed

EFFECTIVE March 1st the Controller of Chemicals has now relaxed the controls regulating the distribution and use of penicillin in Canada. This has been made possible by the satisfactory increase in production, both in Canada and in the United States, and by the still more pleasing fact that the demand in the theatres of war has not been as high as had been anticipated. Since early October Canadian production has been sufficient to meet not only our military needs but our civilian requirements as well. Prior to that date all Canadian production had been reserved for military use, and that used for civilian needs had come from the United States.

Under the new regulations hospitals will obtain penicillin through their regular drug trade channels. Penicillin will be available to the retail drug trade and physicians may obtain it through the local druggist or from supply houses. Penicillin from American producers may be available in the near future.

Price limits for the retail trade, which would need to include sales tax, have been set by the Wartime Prices and Trade Board. However, these would not interfere with the right of a hospital to follow its usual practice, i.e., to advance the price a reasonable percentage to private patients to help meet the loss on the non-pay patients. The Government looks upon hospitals as consumers, not as retailers. In this connection complaints have been received by the Controller of Chemicals indicating that a few hospitals have not been content with the recognized mark-up of 25 to 50 per cent to help cover the loss on other patients, but have raised the price in certain instances to as high as 200 per cent of cost. This is not regarded with favour.

Although stocking of the product by the retail trade for public use will greatly increase the demand, assurances have been given by the manufacturers that they will safeguard the interests of the patients in hospital.

It is of interest to note that the use of penicillin by the public hospitals rose from 360 million Oxford units in August, the initial month of distribution, to 1650 million units in January. During that period the price dropped from $6.00 per 100,000 units to $2.85. Of the approximately 700 hospitals entitled to a quota during that period, 156 did not at any time order penicillin. These were small hospitals and, presumably, did not have any patients for whom penicillin would have been indicated.

Possible Results

The relaxing of distribution control has raised the question of possible wastage through improper use, or at least in ways not approved by responsible medical authorities. There has been so much publicity respecting this "miracle" drug that its indiscriminate use for almost everything under the sun can be anticipated. There will probably be much self-medication for colds, influenza, "kidney trouble" and other condi-

tions for which it has little or no value. Self-medication for gonorrhoea and syphilis may be anticipated, with disastrous results to the patient and others if a complete cure be not achieved. We may even find it advertised in face cream for acne, in tonics to restore hair, and in soap for B.O. The radio may urge us to take it thrice daily in our dental cream, on our shaving lather or perhaps on lipstick to sterilize kisses. It is not at all likely that the present manufacturers would bring out such products, but others more enterprising than scientific might buy up the necessary domestic or imported penicillin. However, we understand that the Canadian product is being limited to parenteral use only.

To a large extent this limitation will restrict self-medication or the unnecessary use of penicillin in proprietary mixtures. Except in the treatment of certain throat infections, penicillin would seem to be of value only when given parenterally. However every nurse and every insulin user has a syringe and it might not be too serious a matter for some people to get the means of taking a "shot". The tendency of penicillin to deteriorate after a period of months, a tendency which is hastened if it is not kept in a refrigerator, also may limit its indiscriminate use to some extent. The date of manufacture appears on the package, but not the estimated date of loss of potency.

Hospitals should continue to keep a reasonable supply of penicillin on hand for emergency use. With wider use it may be more difficult to get supplies over week-ends.

Effective control presents certain difficulties. The Controller of Chemicals does not feel that restrictions in distribution and use can be continued by Munitions and Supply in view of the increased availability of the product. The policy of the Department of National Health in administering the Food and Drugs Act has been to insist that the purchase of a drug require a doctor's prescription only when it is obvious that such a drug or product is habit-forming or a possible source of danger to the person using it. Penicillin therapy does not have the clinical complications noted occasionally with the sulphonamides and other drugs. Quality is hardly a factor, for present products are all of high quality. Should public usage exhaust the supply, particularly in view of the need in other countries and for the use of UNRRA, it is likely that the C.P.R.B. (Combined Production Resources Board) would step in and again restrict usage.

There is a likelihood, too, that penicillin may have quite an extensive trial by the medical profession for many conditions other than those approved by the Medical Advisory Committee. In all probability further clinical studies will confirm certain hopeful preliminary observations in penicillin therapy, while other optimistic statements will be proven to have been unwarranted. Its exact place in the treatment of syphilis is still to be determined. Its uselessness in many other conditions has already been reasonably well proven. Although physicians will be under pressure from their patients to "try penicillin anyway", perhaps on threat of getting another doctor, it is hoped that during the war period at least the still limited supply of penicillin will be used only where there is reason to believe that it will be of real benefit and would be the best form of treatment to give.

All Public Hospitals Entitled to Municipal Priorities

MR. G. H. LASH, executive assistant to the War Assets Corporation, the organization which controls the resale of surplus war equipment, has replied to our letter asking for clarification of his use of the terms "public" and "semi-public" in reference to hospitals in his article in the January issue of *The Canadian Hospital* (page 35). Mr. Lash writes as follows:

"In our thinking, public and semi-public hospitals definitely fall within the categories that you describe as public and voluntary hospitals. In other words we look upon a semi-public hospital as one which is partly supported by public funds, either through public grants or by payment of public funds for the care of indigent patients. Under our description, a private hospital is one which is operated on a profit basis and accepts only patients who are themselves required to pay a set scale of fees. A number of sanatoria would, I think, fall within this category, whereas all the better-known hospitals in the country would not.

"While we have extended to public and voluntary hospitals the privilege of enjoying the priority granted to municipalities, under the conditions stated in the article which was published in the January issue of "The Canadian Hospital", we feel that the responsibility of making the necessary arrangements with the municipality rests upon each hospital and is not that of the Corporation. We can only go as far as to say that if a municipality wants to submit a list in behalf of a hospital, we shall honour the request.

'Because the Corporation is only now beginning to get into its stride, all municipalities have not been officially notified of these priority arrangements, although the subject has been mentioned very widely in the press. However, within a month (early March—Ed.) every municipality will be made aware officially about these priorities and how they may be exercised."

It is obvious from this letter that the War Assets Corporation is following the general listing of hospitals as "public" or "private" that is now followed by the provincial governments and also by the Dominion Bureau of Statistics and the Department of National Health.

Revised
Memorandum of Arrangements

between

DEPENDENTS' BOARD OF TRUSTEES and the CANADIAN HOSPITAL COUNCIL

concerning the handling of hospital accounts of

DEPENDENTS OF MEMBERS OF THE ARMED FORCES

(Effective March 15, 1945)

1. The Board will not accept automatic liability for hosiptal accounts of dependents but will consider methods of facilitating the submission of applications for assistance by dependents who claim inability to meet hospital accounts.

2. The Board will furnish on request, to any hospital which is party to this arrangement, a supply of Form D.B.T. 1—Application for Assistance—for use of qualified dependents. Applications for assistance will be accepted for consideration by the Board only if made voluntarily by such dependents; applications may not be made by the hospitals.

3. The Board will endeavour to give advance consideration to applications involving non-urgent or elective surgery, to the end that an indication may be given as to the likelihood of aid being granted by the Board and as to the extent of such aid, prior to the dependent's entry into hospital.

4. The Board will continue its present practice of investigating individually applications made by dependents and of determining as a result of such investigations if, or the extent to which, assistance will be granted.

5. The Board will endeavour to expedite the investigation of applications in which payment of hospital accounts is involved.

6. Hospitals will be free to render accounts to dependents on such basis as the hospitals may determine, but insofar as dealings between the hospitals and the Board are involved, the accounts will be deemed to have been rendered on the basis set out in paragraph 7 below.

7. ******For the purposes of the Board, an account rendered will be assessed on the basis of the rate charged to a public ward paying patient and that rate will include such services as are normally provided to an individual paying such public ward rate. Extras listed on Schedule "A" following and not normally included in the rate normally charged to a public ward paying patient will be assessed on the basis of the said Schedule "A" and no other extras will be paid by the Board, provided however that any regional Dependents' Advisory Committee on the advice of its Medical Advisers may recommend that such assessment be increased on any specific item of such extras or that payment be made in respect to an item not included in the said Schedule "A", where exceptional circumstances are deemed to warrant such action.*

(NOTE: The foregoing paragraph shall not be deemed to over-ride any specific agreement as to the assessment of accounts made by any regional Dependents' Advisory Committee on the direct authorization of the Board with any hospital or group of hospitals within the territory assigned to such regional Dependents' Advisory Committee).

8. Where any payment is made by the Board but such payment is less than the full amount assessed as above, the hospital will be free to collect from the dependent the difference between the account as so assessed and the amount actually paid by the Board. However, if the dependent has requested and has been provided with private or semi-private ward accommodation, and the account has been assessed and any payment thereon made by the Board in accordance with paragraph 7 hereof as though only public ward accommodation had been provided, the hospital will be free to make its own arrangements with the dependent in respect to the payment of any balance due because of such private or semi-private accommodation having been requested and provided, after allowing for any payments made by the Board.

9. If, as a result of agreement between the hospital and the Board, full settlement of an account is to be made and accepted in an amount less than that billed by the hospital to the patient, or if only partial payment of an account is to be made by the Board, payment will be made by the Board direct to the hospital with notification to the dependent only to the effect that the account has been settled in full, or that an adjustment has been made leaving $.....payable by the dependent. *(Schedule "A" on next page)*

**Section 7 here in italics replaces Section 7 of the former agreement published in the March, 1944, issue of "The Canadian Hospital".*

Schedule "A"

Basis of assessment of "extras" as per paragraph 7—Memorandum of Arrangements, Dependents' Board of Trustees and Canadian Hospital Council . . . effective March 15, 1945.

Approval of this arrangement by the Canadian Hospital Council does not necessarily bind the individual hospital. This agreement does not interfere with the special all-inclusive plan now in operation in Manitoba.

Laboratory Tests

Basal Metabolism	$5.00
Blood:	
Complete examination, including red and white cell count, haemoglobin, differential, leucocyte, etc.	5.00
Blood examination in connection with sulphopyride content	1.00
Wassermann to be done by provincial clinics, otherwise	2.00
Typing blood for transfusion—recipient $1.00 —donor $1.00	2.00
Sugar tolerance test completed with parallel estimation of urine	5.00
Complete renal function tests	5.00
Other tests not enumerated above	2.00
Cerebrospinal Fluid:	
Fluid and full reports on organism, cell count, and chemical examination and/or luetic tests (lab. examination only)	5.00
Faeces:	
Examination for blood, pus, ova or parasites, etc.	2.00
Cultural examination	3.00
Gastric Contents:	
Chemical and microscopical examination, including test meal	5.00
Pus: Exudates, Transudates	
Direct examination for micro-organisms	2.00
Cultural examination for micro-organisms	3.00
Sputum:	
Examination for tubercle bacilli and other organisms	2.00
Urine:	
Routine qualitative chemical and examination of deposit	2.00
Quantitative analysis of any constituent additional	2.00
Acetone and diacetic acid	2.00
Direct examination for micro-organisms	2.00
Cultural examination for micro-organisms	3.00
Animal inoculations for tubercle	5.00
Ascheim-Zondek Test, local fee, not to exceed	5.00
Friedman's Test	$3.00 to 5.00
Quick frozen section	5.00
Routine surgical sections	3.00

Miscellaneous

Blood Donor for transfusion (local schedules) up to	25.00
General Anaesthesia (where given by qualified physician whose services are paid for by the hospital)	
Minor operations	5.00
Major operations	10.00
Gas anaesthesia—cost of gases used extra.	
Spinal anaesthesia (if given by a qualified physician whose services are paid for by the hospital)	10.00
Operating room—major	10.00
—minor	5.00
Case room	10.00
Fever therapy—per treatment	10.00
Cystoscopy and associated examinations	10.00
Electrocardiogram (technical service only)	2.00
Hospital board for special nurses (when services paid for by Board) allowed at local rates.	
Special medication:	
(This would be for special drugs, such as penicillin or sera, the cost of which would be abnormal. This would not apply to ordinary drugs or solutions normally included with the room rate to ward patients)	at cost
Complete set of allergy tests	5.00

X-Ray

General Conditions:

These fees are based on the number of films usually necessary, but the exact number of films used is left to the judgment of the individual radiologist. However, in any event, a sufficient number of views must be taken in order to give the results desired. Unless otherwise specifically noted, the fees include all fluoroscopic work in connection therewith, and also include any chemicals found necessary to the work, such as barium, lipiodol, etc., and also include a written interpretation of the films, or of the fluoroscopic examination associated with the taking of the films.

Chest for pulmonary or cardiac diagnosis	$6.00

Colon with barium enema	7.00
Extremities, below the shoulder joint or the hip joint	4.00
Gall bladder, including administration iodeikon or medication	10.00
Gastro-intestinal examination complete	15.00
Kidneys, ureter and bladder, complete	10.00
Shoulder joint, hip joint, pelvis	7.00
Skull, including frontal and accessory sinuses or mastoid	7.00
Spine—any portion	7.00
Teeth, entire set at least 10 films	7.00
Teeth, single films up to 9, each film	.75
One flat chest film for lung and heart diagnosis	3.00
Localizing foreign body in eye with Sweet's localizer or equivalent	10.00
Encephalogram, ventriculogram, myelogram	15.00

Treatment by Radiation

By radium emanations:	
External lesions	$10.00 to 25.00
Lip	25.00
Tongue, rectum, uterus	$25.00 to 50.00
By deep x-ray therapy:	
Neoplasms in any locality, per treatment	5.00
Superficial	3.00

(When both radium and x-ray are found to be necessary, both fees may be paid in the same case.)

Although approved by the Executive Committee of the Canadian Hospital Council, acceptance of these details will be a matter of arrangement between the Dependents' Board of Trustees and the hospital, presumably after consultation with, and with the approval of, the pathologist and radiologist.

Institute on Ward Administration at U. of O. School of Nursing

Twenty-two registered Sister nurses from various parts of the Dominion attended the Institute on Ward Administration at the University of Ottawa School of Nursing from January 22nd to 26th, 1945.

The lectures centred around the following topics: modern trends in nursing; public relations and public education; the philosophy of education as applied to clinical supervision; the ward as the laboratory to the school of nursing; ward teaching; qualifications and qualities of the supervisor; efficiency rating of the students; the auxiliary worker; the supervisor and the graduate nurse; vocational guidance and the supervisor; the undiagnosed tuberculosis case in the general hospital; and fire hazards.

Round tables were conducted in professional ethics and saving of time and supplies. Demonstrations were carried on at the Ottawa General Hospital in the paediatric, obstetrical, medical and surgical wards to exemplify the various types of ward teaching. At the Strathcona Hospital for Contagious Diseases a very interesting demonstration explained isolation technique in detail. This was followed by a visit through the hospital.

When the busy week came to a close the Sisters, who had participated freely and enthusiastically in the discussions, were unanimous in concluding that the supervisor should be a well-prepared executive, experienced in her special field; that the ward situation provides for much stimulation, for practice which has a real purpose, for learning which will be retained, and for developing important attitudes and appreciations in the student.

—*Sister Madeleine of Jesus, s.g.c.*

Social Security Legislation in New Zealand ----*and How it Works*

By NORMA MORTIMER

NEW ZEALAND—land of radiant sunshine, mid-summer Christmases, luxuriant growth and birds of brilliant plumage. Such things are sufficient to arouse our interest in a sister Dominion. Added to this natural interest is the fact that the daily press, current periodicals, public speakers, make frequent mention of this land below the sun. This publicity centres largely around the social legislation that has been enacted by the government of that country. In the words of the Honourable Walter Nash, Minister to the United States from New Zealand and its former Minister of Finance, "New Zealand has justly earned for itself a reputation as the world's economic and social laboratory".

Those who voice comment on this legislation would appear to be divided into two distinct groups—those who look through rose-coloured glasses which impart to all things an unnatural light, and those who gaze through smoked lenses so that all the glow is obliterated. Is it possible to view the situation without the aid of tinted spectacles and to find a true picture of New Zealand's endeavours somewhere between these two extremes?

Speakers for the Co-operative Commonwealth Federation are prone to point to New Zealand's social security measures as proof positive of the advantages to be attained under a socialist form of government; this despite the fact that New Zealand's Social Security Act was conceived, enacted and put into operation by a Labour government with definite right wing tendencies.

Two facts are continually quoted regarding New Zealand: one is the low infant mortality rate, the other the low general death rate. Speaking of their infant mortality rate, 31.18 for 1943, Mr. Nash admitted that this figure does not include the Maoris, that the Maoris should be included, *but they are not included.* In Canada the rate for 1943 was 54, but the figure includes Indian, Eskimo and other groups within the country known to swell the infant mortality rate. In 1943 the tentative figures for Indians and Eskimoes were 800 deaths out of 4,230 live births. One can readily see the effect of the inclusion of such figures in computing the Dominion rate. Also there is great variation in the rates for the provinces: New Brunswick and Quebec are listed as 68 and 67 respectively per 1,000 live births, while British Columbia's figure is 38 (including Indians). New Zealand's salubrious climate and much more homogeneous population may be credited with assistance in the maintenance of a low infant mortality rate.

The second much vaunted fact is a low general death rate. For the five-year period up to 1940 this was 9.2 in New Zealand, while Canada's rate for the same period was 9.8; again Canada's rate includes the Indian and Eskimo groups. When the rigours of our climate are considered, the vast spaces with sparse settlement and the mixed groups in-

Miss Mortimer is a member of the staff of the Department of Economics, Canadian Medical Association.

habiting our country, the difference in death rate would seem to be practically negligible.

Again, we find the length of life is being featured in New Zealand. The latest figure (quoted by Mr. Nash) is that the expectation of life in New Zealand is 67 years. In Canada, the Dominion Bureau of Statistics on January 31st, 1945, released tables showing the expected life span of the 1 year old girl now is 68.73 years and of the 1 year old boy 66.14 years.

New Zealand's achievements are outstanding and worthy of emulation: no attempt is herein being made to belittle what she has done. Rather is it our desire to recognize clearly what has been done and to note to what extent Canada has achieved comparable results.

Social Security Legislation

But what of their social security legislation? The Social Security Act was passed in September, 1938, and the Social Security tax was collected for the first time in April, 1939. The Act provides for monetary benefits in the form of universal superannuation, family benefits, widow's benefits, sick benefits, etc., under the direction of the Minister of Social Security. The Act also provides for extensive health benefits; this section is run by the Minister of Health. Although the Act intimated that complete health benefits—medical, surgical, hospital, pharmaceutical, etc.,—would be available immediately, such was not the case. The government had made no previous arrangement with the medical group for the provision of these services, nor had it undertaken the building and equipping of the required hospitals. Thus at the outset there was a certain amount of discontent on the part of the people who were required to pay a social security tax but who were unable to receive the stipulated benefits. Later in 1939 hospital and maternity benefits were provided; 1941 saw the introduction of general practitioner service, pharmaceutical benefits and radiological services and in 1942 physiotherapy was made available. To date dental and specialist (as such) benefits are not arranged.

What are the present arrangements?

Hospital benefits: All treatment and care in a public hospital is free to the patient. For each occupied bed the State pays the sum of 9 shillings per day to the hospital Any deficit in the cost of maintenance is shared equally by the State and the hospital district.

When the social security legislation was introduced, there was a *shortage* of hospital beds and equipment. This condition has been aggravated due to the fact that, as the Director-General of Health has said, "the policy of the government has been to utilize the public hospital system for the treatment of sick and wounded soldiers rather than to duplicate the system by establishing separate military hospitals with their own medical staffs. It is considered that this policy is more economical of medical personnel and medical equipment, both of which are strictly limited". This is probably quite true, but one is tempted to wonder whether the average New Zealander who has paid for and has been promised social security benefits, would endorse this course of action.

Maternity care: Cost to the mother, nothing; payment to the doctor, 5 guineas. This payment includes prenatal care and delivery, though it may be increased in the case of complications. The mother may have a resident nurse for fourteen days, in which case the nurse is paid 13 shillings per day from the Fund. If the nursing service is on a visiting basis the payment to the nurse is 5 shillings per visit. Or the mother may elect to go to a public maternity hospital, in which case she pays nothing. If she selects a private maternity hospital, the state pays the hospital 9 shillings per day and the patient is responsible for the balance.

Medical Benefits

General practitioner service: This has proved to be the knotty problem in the operation of the Social Security Bill and, though the service was inaugurated in 1941, there remain some knots to be untangled before a smooth skein of health benefits can be handed out to the expectant New Zealander. The government promised general practitioner service, but there were not sufficient general practitioners to render the service, nor was any attempt made to determine with the practitioners the price to be paid for this service.

The plan now in operation is a fee-for-service one, with free choice on the part of both doctor and patient. The fee set by the state is 7 shillings 6 pence for home or office visit, with 12s 6d for such service after 8 p.m. or on Sunday. Some 22 per cent of New Zealand's doctors have accepted this fee schedule in full payment of their service and collect this amount monthly from the Health Department for each service rendered.

A large percentage of the doctors, however, require the patient to pay an additional 3 shillings, or require him to pay the former full fee of 10s 6d and leave him to collect the refund of 7s 6d from the Department.

In addition to these various methods of payment, both salary and panel types of remuneration are in operation in certain parts of the country. This lack of uniformity has

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A grammar school at Auckland, North Island.

Getting Full Production from

Laundry Machinery

By MR. R. J. MORROW,
Secretary-Treasurer, Canadian Laundry Machinery Co. Limited.

WE know the very precarious position we have been in for some time with respect to obtaining equipment. Therefore, with this background it is opportune that hospital management should give particular attention to good maintenance and proper operation of your equipment so that you can keep operating efficiently until victory is won.

The laundry represents a vital part of any institution, and upon the laundry management falls the responsibility of guaranteeing continuous, uninterrupted operation during the national emergency. Heretofore institutional management has been concerned with economical production of its various departments, even though some of its high production figures have been reached at the cost of prematurely worn out machinery. Today replacement machinery and, in some cases, simple repair parts are difficult to obtain, or not available at any price. The question before us now is: What can institutional laundry managers do to keep operating with the machinery they now have.

Good Maintenance

In most institutions the responsibility for maintenance of the machines in the laundry rests with the Engineering Department. Good maintenance is only accomplished through an organization managed by those who have a complete mechanical knowledge of the machines for which they are responsible. Coupled with this there must be a systematic, tireless routine of lubrication, adjustment and replacement of worn or broken parts to give perfect machine performance.

We then come to the subject of management. The efforts of the finest maintenance organization can be nullified by faulty operation. Take, for example, the laundry wash-room. The machines in your plant may have the very best of attention in regard to lubrication and general machine adjustment and repair; yet abuse of the machines through overloading may cause frequent machine breakdowns and premature complete failure. Like any other piece of machinery, laundry washers are designed for a definite, maximum load.

Given at the fall meeting of the Ontario Hospital Association in Toronto.

Dangers of Overloading

The motor gearing strength of the cylinder sheets and general machine make-up are arrived at by engineers who design laundry washers for a predetermined load they are to carry. Many laundry managers throw all of these engineering principles to the winds and sanction huge overloads for washers, simply because there is space enough in which to put these overloads. The result of such operation is an added strain on all of the washers' driving parts, causing failures of bearings, gears and motor, distortion of cylinder doors and sheets and, in some cases, actual cracking and breaking of the cylinders themselves.

Correct washing and distribution of supplies and correct rinsing cannot be accomplished in overloaded cylinders. Although the washers themselves suffer through the abuse of overloading, the evil does not end there. It extends on through the plant to whatever other machines the work must go.

Overloading is only one of the abuses to which washers can be subjected. Slamming of cylinder and shell doors brings about structural weaknesses in the doors, sills and latch parts, resulting in torn work. Jogging the inch buttons up and down through numerous short, jerky movements each time the cylinder doors are spotted also causes unnecessary strains on the motor and entire drive mechanism.

Improper Extracting

Now let us diagnose the trouble that results from incorrect extractor operation. Here again we will assume that the machines have the finest of maintenance attention from a qualified mechanical organization, and that the basket and motor have been checked periodically to make sure they are running at the rated speeds.

Incorrect extractor operation may be classified under two headings: improperly-balanced loads and insufficient extracting time. Laundry extractors are designed to handle loads that are not perfectly in balance. The out-of-balance condition and resulting vibration is absorbed by rubbers or suspension cable assemblies built into the machine for this purpose. There is a definite limit, however, to the amount of vibration these parts are capable of absorbing. To exceed this limit and permit the extractor to run with an excessive amount of vibration means that the machine is running in a dangerous condition. Failures of bearings, spindles, baskets and other parts of the machine can often be traced to the continued operation of poorly-balanced loads.

Where careless loading of extractors is practised, frequent stops for rebalancing are necessary. This means that severe loads are imposed on the motors. Extractor motors are designed for a maximum number of starts per hour. To go beyond this number of starts means increased motor temperature and eventual motor failures. When motors fail on such high-starting current machines, they fail with little warning. Today motor repairs and motor replacements are becoming more and more difficult. Therefore, lost time in shutdowns due to motor failure must be avoided. This is the place where the common sense of operator and supervisor must be brought to

bear, and laundry management should insist on careful loading at all times to avoid the penalty of machine failure.

Laundry managers should insist on the use of such mechanical timing devices as are provided, or that extractor operators keep accurate time records of every load. The length of time that various types of loads should be run can best be determined by actual extraction tests made by the foreman or manager in the plant. Work leaving the extractors should at no time have a retained moisture content of over 50 per cent of dry weight of the load. Maximum efficiency is dependent upon this factor.

Haste Makes Waste

Although insufficient extraction may not be detrimental to the machine itself, it creates a condition in the work which results in trouble throughout the plant. It means that work being sent to the flatwork ironer, tumblers and presses contains a greater amount of moisture than these machines are designed to handle efficiently. Many laundry managers or washroom foremen think it is good practice to cut down extracting time to suit washroom conditions or general conditions throughout the plant. They pride themselves on being able to get work through by this method when volume is exceptionally heavy. But they fail to realize the actual result.

One of the first indications of under-extracted work going through a flatwork ironer is either the rolling of work in the machine or the delivery of damp work at the reeciving end. To compensate for this, additional pressure is jammed on the ironer rolls. Thus the ironer is transformed into a combination extractor and ironer. When excessive pressure is used, cover pulling and padding failure are encountered. The additional moisture, instead of being evaporated by the ironer itself, is passed on to the aprons, causing apron wrinkles in some cases. Replacement of the apron then becomes necessary. Sometimes you will find that when work is being passed through the ironer and is received damp on the receiving end, the operator merely slows the machine down to the next speed. This definitely causes a drop in production.

Excessive Ironer Pressure

When excessive pressure is placed on flatwork ironer rolls, the roll boxes and roll shafts become worn and an increased load is placed on the entire gear train which drives the ironer. Mechanical failures of machine parts result from such practices. Thus, under the pretext of saving what would be only a small time at best in the extraction department, a great deal of waste results.

The flatwork ironer represents a large investment and is a very important piece of laundry machinery. Its correct operation is dependent upon its being given prescribed operating conditions. Let us assume that the flatwork ironer in your plant has the ultimate insofar as steam, return and maintenance is possible. From this point on responsibility for operation of the ironer rests with the laundry management. Heretofore, excessive replacements of aprons, padding, ribbons, etc., may not have been such an important item, but the situation may be different in the not-so-distant future.

Preserving Padding and Aprons

Laundry managers should avail themselves of every opportunity to educate themselves and their organizations in obtaining the maximum their flatwork ironer is capable of producing, also the greatest length of life from each piece of padding, cover cloth or apron cloth that is applied. This can only be done through a thorough knowledge of what to expect from a flatwork ironer. A foreman, manager or some other responsible person should be delegated to start up the flatwork ironer each morning. He should be certain that the ironer has a 30-minute pre-heating period with a partially-open main valve, and that the machine is completely filled with 100 pounds of steam pressure before being put into operation. He himself should apply the pressure to a correct point. He should be thoroughly familiar also with the automatic control of the aprons and, when starting up the ironer each morning, should double check as to the operation of the apron controls.

The aprons should be kept tight enough so that all controlled rolls are functioning and no rolling of work will take place in the inside apron where the work is conveyed over the bottom of the chest. The control of aprons in some cases presents quite a problem to the institutional laundry operator. We find that the greatest trouble in controlling aprons is that the person who is responsible makes all his attempts to control the aprons

(Continued on page 74)

The Detailing of Nursing Sisters to Civilian Hospitals

The Canadian Hospital Council has been asked concerning the arrangement made for the detailing of nursing sisters to civilian hospitals.

It is our understanding that this particular arrangement has been authorized by Order-in-Council P.C. 7429 of October 3rd, 1944. By this Order-in-Council nursing sisters may be assigned for duty in civilian hospitals for a limited period.

It is necessary that the D.M.O. be satisfied that such nursing sisters can be spared from military service and that the civilian hospitals cannot fill their requirements from available civilian registered nurses. Only nursing sisters attached to military hospitals for quarters and rations may be detailed. Those drawing subsistence allowance cannot be detailed.

The D.M.O. is authorized to limit the term of the engagment of such nursing sisters and must stipulate that they return to duty in military establishments on demand.

Nursing sisters so detailed will continue to receive army pay and allowances, with the exception of subsistence allowances. They will be provided with rations and quarters by such civilian hospitals. No payment will be made by the hospitals directly to nursing sisters.

Civilian hospitals so supplied with nursing sisters will pay to the Department of National Defence such remuneration as is ordinarily paid for the services of registered nurses employed by them on a temporary basis. The D.M.O. will advise the D.O.C. as to what rate is applicable.

Nursing sisters so detailed will continue to wear military uniform.

Flower Arrangement

By MISS LOUISE HERINGA,
Department of Horticulture, Ontario Agricultural College, Guelph, Ontario.

OFTEN our sick people have to look at an array of flowers that are anything but pleasing to behold, generally due to overcrowding of the container. If we jam our flowers together till they are nothing but a blot of colour and so much green, we take away their individuality and beauty, and if the vase is one of those badly-proportioned and over-decorated types, placed too near a radiator in a draught, not only can there be no appreciation of beauty, but the ensemble kills the life of the flowers.

To arrange cut flowers, we need some kind of holder and suitable containers (vases, bowls or dishes). These should be simple in form without decorations—never the grotesque statues with holes at weird angles. Nor does one have to rely on flowers alone. Branches of trees, evergreens and shrubs all offer interesting material to form pleasing line and colour combinations.

Two types of containers are generally used in hospitals. One is the green funnel-shaped metal container, the other a glass jar, clear or green. Neither of these has any beauty to boast of, but are entirely dependent on the flowers and the way they are arranged to make these ugly ducklings more than mere containers. The funnel-shaped one should be used for long - stemmed flowers (gladioli, peonies, etc.). The other is suitable for a great variety of flowers with shorter stems proportionate to the height of the vase.

Arrangement

If there are too many flowers jammed together in either of these containers, the difficulty may be remedied by removing part of the flowers, cutting them to various lengths and replacing them at angles to come down and blend with the jar, breaking the harsh line between flowers and vase.

When there are not sufficient flowers to hold their arrangement, a simple trick to keep them in place is to crumple some two-inch mesh chicken wire and wedge it in the container. Fill almost to the top with water and insert the flowers singly to make an artistic bouquet.

Many a bouquet of flowers will be improved with some added green from shrubs or evergreens rather than the too often used garden asparagus.

The arranging of flowers is an art, but even a little care and thought can enhance their beauty to make them a joy for patient and visitor alike. Many an inexpensive container can be made effective when a piece of crumpled chicken wire is placed in it to hold the flowers in place. Many novelty shops have flower holders, of which the two best types are the spike and daisy holders. Line arrangements may at first seem very difficult but with either of these manufactured holders they are really quite simple and lots of fun. This type of arrangement could be an interesting pastime for convalescents.

Above: Line arrangement of pussy willow and a few tulips.

Address at 1944 meeting Women's Hospital Aids Association, Ontario.

Why not let them try to arrange their own flowers?

In all arrangements, whether composed of flowers or just twigs and greens, line and form are very important. Colour, too, plays an essential part. Bouquets of one colour are the simplest to arrange and the most restful to the eye. If of mixed colours one should try to group the colours to avoid spottiness and place the heaviest and darkest near the lower part of the arrangement.

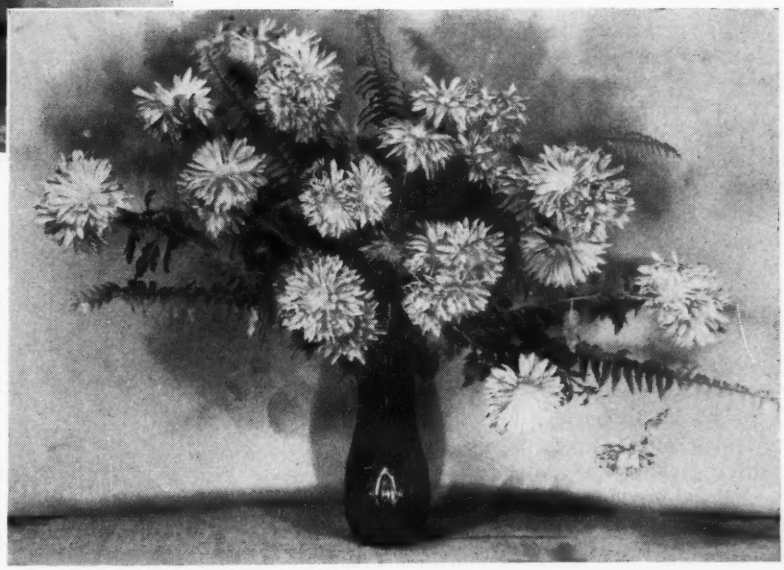
Do's and Dont's

(same amount of flowers used in all three pictures)

Left: Flowers jammed together are nothing but a blot of colour and so much green.

Above: Flowers cut to various lengths and replaced at angles to come down and blend with the jar, thus breaking the harsh line between flowers and vase.

Below: Flowers arranged with the help of crumpled up two-inch mesh chicken wire.



The keeping of flowers should be given consideration.

Depth of Water: The stems should be in the water a few inches. Almost all water is absorbed at the base of the stem. Carnations are an exception to this rule.

Changing of Water: It has been proved that changing the water and cutting the stems daily has little value in prolonging the life.

Treatment of Stems: Flowers

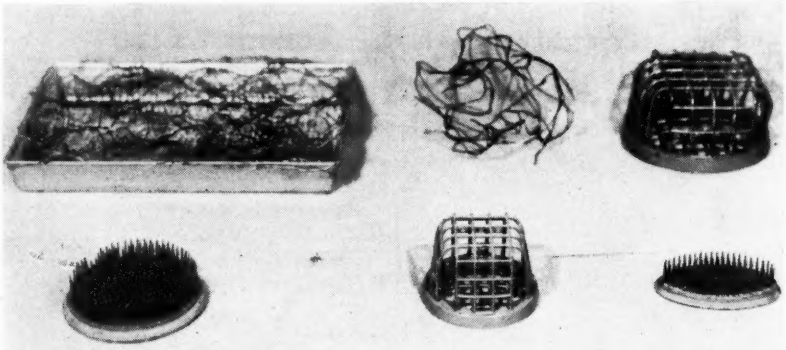
Also hydrazine sulfate solutions might be found beneficial.

For those who desire to perfect this delightful art of arranging flowers well, helpful books on this subject may be found in most public libraries.

Left: Chrysanthemums, Barberry leaves and berries.

Centre: Holders—upper left, baking dish filled with chicken wire. Middle, piece of crumpled two-inch mesh chicken wire. Lower left and right, pinholder. Middle and upper right, daisy holder.

Below: A graceful arrangement of Columbines and Thalictrum.



which have a sticky sap will stand up better if the stem is singed (such flowers include poinsettias and poppies). Singeing can also be done by way of boiling water. Half an inch of the stem is held for 1 to 3 minutes in boiling water. To revive badly wilted roses, poinsettias and dahlias, place in water as warm as the hand can bear. Usually in a short time they will be quite revived and can be returned to their former vases.

Of the chemical treatments tried, according to the Ohio State University bulletin, very few proved to be beneficial in prolonging the life of flowers—their main help lies in preventing pollution of the water. A commercial product "Flora Life" has been tested and is well worth trying, particularly on roses and carnations.

Keeping the Hospital

Spick and Span

By MISS ANNE M. COULTER,

Chief Dietition and Housekeeper, Queen Elizabeth Hospital, Toronto.

INSIDE surface maintenance includes the cleaning of walls, floors and windows and, to that extent, is the work of the housekeeping staff. The problem is: how can this work be done thoroughly, harmlessly, and economically, with the least possible inconvenience to both the patient and the nurse. One of the most essential factors is co-operation. I know a cleaning unit is often a great source of annoyance to the nurse, when they come to take over a ward; the ward must be cleared and the regular routine is disrupted. But patient or nurse can also become a source of annoyance to the polisher, when she insists on walking on his wet wax and spills water on his newly polished floors. So it behooves each to have patience with the other and to interfere as little as possible with the routine of the work to be done.

The daily cleaning goes on quietly and systematically as a regular part of the life of the hospital; the ward maids sweep and dry-mop the floors and dust the furnishings; the floor man cleans up the spots on the floors, applies fresh wax, if necessary, and polishes them. These spots will usually respond to light scrubbing, but in some cases it will be necessary to use fine steel wool or sandpaper to remove them. Then in the case of oil, ink, and similar stains, a special treatment will be required.

There is a certain routine to be followed weekly. It is the duty of the ward maid to wash, with cleaning solution, all painted furniture and to clean and oil all varnished ones—a certain quota each day. She also applies fresh wax to the tops of all dressers and bedside tables. The tops of all bedside tables and dressers in our public and semi-public wards are covered with an inlaid linoleum; we keep this well waxed and polished to protect the surface from wear and tear. Every week the floor man cleans radiators and baseboards and applies fresh wax and polishes each floor as needed. Some wards will require this floor treatment more frequently than others. At the Queen Elizabeth Hospital our difficulties in this respect are increased by the fact that we are caring for helpless patients who spill and drop things and who move about in wheel-chairs. These wheel-chairs are also quite a problem—the patients wheel themselves on the lawn and, like children, seem to delight in running their chairs through every mud puddle and wet spot they can find. This dirt and wet is carried on the wheels into elevators, halls and wards, and necessitates extra polishing.

Walls

In addition to this daily and weekly routine, the walls of all rooms are washed at regular and frequent intervals. The frequency of this procedure depends, to a certain extent, on the location of the hospital. In the city, where we have so much smoke and grime, every ward should be washed at least once in ten months, and preferably once in eight. Even when this is done some sections of the building will become very dirty and require more frequent attention. Certain parts of a room—over a radiator or ventilator, or where there are draughts at a window—will often show a very bad streak of dirt before the ceiling or remainder of the walls really need washing. These soiled spots can be improved by dry dusting with a long wall brush and a clean duster, but washing such sections often leaves a watermark which makes the rest of the room look very badly. Finger marks and smudges are sometimes caused by cleaners and window washers putting wet hands on the adjacent wall, by engineers servicing radiators and other equipment and by nurses and other employees cleaning. We have found that a very small amount of paste cleaner on a clean cloth will give excellent results. In our halls, particularly, where we have up-patients who guide themseves down the hall by leaning with their hands on the wall, we have a lot of trouble with finger marks. To lessen the labour involved in keeping the walls clean, we have a dividing line about an inch wide along the wall five feet or so from the floor; so that the regular floor man or ward maid can wash sections of the lower division of the wall without calling in the wall-washing unit. The dividing line makes the difference between the washed and unwashed part scarcely noticeable.

In the case of single rooms where patients change more frequently, the work of the wall-washing unit can go on when the room is vacant. But in the ward there is always a quota of patients, and it must be cleared entirely while the work is being done. Usually patients can be removed to a sitting room or solarium for the interval, but this does disrupt the routine of the ward. The wall washers should have good solid equipment —firm ladders and strong planks—so that they can work comfortably and in safety. It is also better that they work in pairs because their ladders and planks are heavy and not so easily adjusted by a man alone. Most of our wall washing is done by hand. Two pails are used for each washer, one to contain the wall washing solution and one for the clean rinsing water. A separate sponge is used in each pail, and each man uses a chamois for final drying and polishing. The binder of all dirt on surfaces is grease or oil to which foreign substances cling. This grease

An address at the October Convention of the Ontario Hospital Association.

or oil must be emulsified, so that it can be rinsed away easily, taking the dirt with it. Sometimes it is more stubborn than others and, in such cases, a stronger cleaning solution must be used. This cleaning solution, diluted as per the manufacturer's instructions, is applied to the ceiling and the wall, commencing at the bottom. Only a small surface is done at a time, and rubbed till dirt and grease is loosened. Then the surface is wiped with a clean sponge. When it is perfectly clean and smooth again, it is dried and polished thoroughly with the chamois. The wall washer should always work in even strokes back and forth, not with a circular motion, as in this way streaks will be avoided and the lustre of the paint preserved. It is also necessary to change cleaning solution often and rinsing water more often still. The washing of painted walls adds much to the life of the paint and, if walls are washed before painting, one coat of paint will often suffice for two, thus reducing the cost of the work. Of course this wall washing is a much more satisfactory process if the wall finish is of fine quality to begin with. All oil paint surfaces can be treated in this way—whether flat, gloss or enamel. There are many good wall washing compounds on the market, but whichever one is used must fulfill three requirements. It must be harmless to the painted surface, harmless to workers' hands, and must leave a nice clean surface, with its original lustre unmarred and free from all signs of streaks.

We come now to maintenance of the floors and, here again, quality material and good workmanship pays. Proper floor preparation, when laid, goes a long way in securing a beautiful floor. Inferior finishing materials will not give best results in the complete protection of the floors and, as a result, the floor will not stand up under constant traffic. The maintenance of each type of floor is a problem in itself, but there are three general steps:

1. Thorough cleaning of the surface and, if necessary, the removal of the old finish.
2. Sealing the surface as needed.
3. Application of the finish coat.

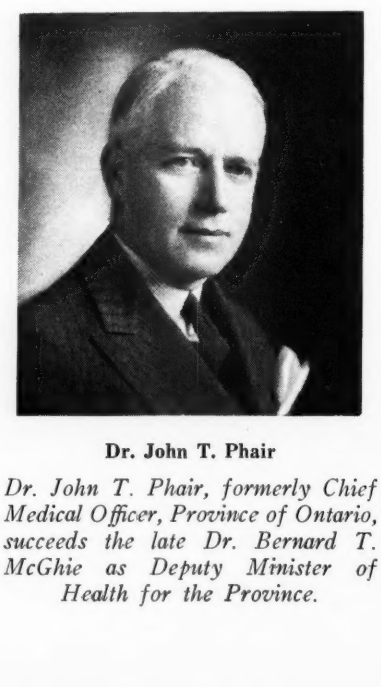
Hardwood floors are cleaned by electric machine, by hand, or a mop, using a cleaning solution of suitable concentration. If the floor is very dirty, a stronger solution may be needed. The scrubbing should be done evenly back and forth till all dirt is loosened; then the dirty cleaning solution should be wiped up and the floor rinsed thoroughly with clean water. The scrubber should use two pails for his work; one to contain cleaning fluid and one the clean rinsing water; and it is very necessary to change both solution and rinse frequently. A varnish or wax coating should never be applied to a floor till it is thoroughly cleaned and thoroughly dried. The use of an electric fan to hasten the drying is of great assistance, specially on damp days when drying is very slow. It is only necessary usually, to remove the surface coat of wax and the dirt will be removed with it.

Only at intervals of possibly three or four months, when a floor has become discoloured by an accumulation of wax, should a thorough scrubbing remove the wax coats down to the wood. If this has been done, the floor must be treated with a sealer. All floor surfaces are more or less porous and, unless these pores are sealed, dirt and moisture will settle in and, under traffic, this dirt will be ground into the wood. The sealer should be applied in one or two thin coats as needed. A new or freshly sanded floor may need three coats of sealer. Each coat must be thoroughly dry before the next is applied. Then comes the third step in the process, the application of the finish. The waxed finish, I think, is used most generally as it does not hold dirt, and is easily cleaned. Some waxes do not require buffing. The wax should be applied with a lamb's wool applicator, evenly in a very thin coat; and when thoroughly dry, polished. Two very thin applications of wax are much more effective than one heavy coat, and an electric fan hastens the drying considerably. We use water wax on all our wards and halls, because we find it stands up well under wheel chair traffic. The surface is hard but resilient, and it is possible to clean up dirty spots, and rewax and polish them with no sign of a watermark on the finished surface. The wax coat should take the brunt of the wear and tear off the floor. We do not usually find this finish too slippery for our use, but if it were so, the wax can be diluted and the slippery effect reduced.

In maintaining cork floor, all the loose dust should be brushed from the floor and the greasy dirt removed by washing lightly with very mild soapflakes. If it is possible to wash a cork floor by hand and cloth only, it is better to do so. However, with the labour situation as it is, we find it necessary to conserve time with a machine. The water used in washing cork should not be too hot, and should be used sparingly. If the floor is flooded with water, it seeps under cracks and loosens the cork. The dirty solution should be wiped up and the floor rinsed with clean water and dried well. In working, only a small section should be wet at a time. When the floor is thoroughly dry, one or two very thin coats of water wax are applied and the surface polished with a piece of blanket under the polisher.

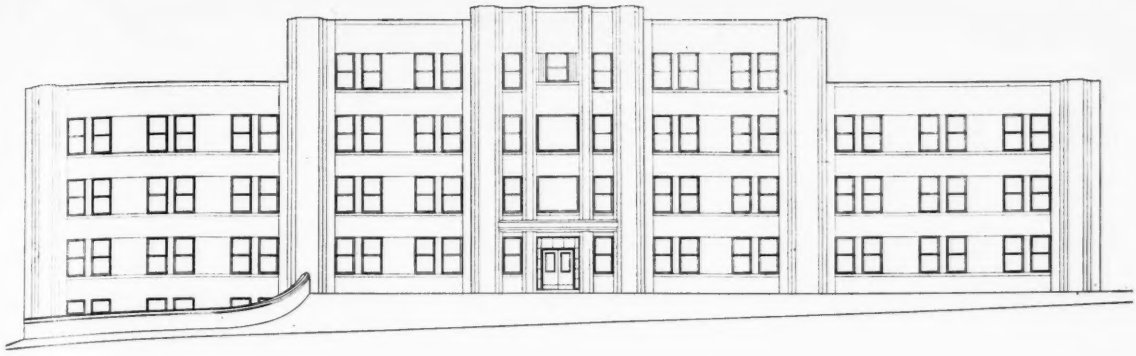
Rubber floors require a still different treatment. Any cleaning product containing either oil or abrasives is very destructive to rubber, causing it to soften and swell. Rubber flooring should be cleaned with clear water if not very dirty or, if a cleaner is necessary, a handful of tri-sodium phosphate in a pail of water or a good commercial rubber cleaner may be used. The floor is dried thoroughly and waxed with a rubber wax. No sealer is required except in certain cases where the rubber has become soft and spongy

(Concluded on page 84)



Dr. John T. Phair

Dr. John T. Phair, formerly Chief Medical Officer, Province of Ontario, succeeds the late Dr. Bernard T. McGhie as Deputy Minister of Health for the Province.



FRONT · ELEVATION

Modern Maternity Wing

at Royal Jubilee, Victoria

By T. W. WALKER, B.A., M.B.,
Superintendent.

THE new 87-bed maternity pavilion at the Royal Jubilee Hospital, Victoria, British Columbia, has been designed to comply with the latest approved technique for maternity work, to eliminate noise, as far as possible, and to centralize nursing services.

Nurseries

These are laid out in units of four. Each unit contains eight bathettes, each placed in its own cubicle. The partitions between the sub-units are plate glass to the ceiling. There is a utility room and a milk room for each nursery, and a large viewing window permits parents to see their babies.

Each nursery is equipped with an examination room for physicians, the child being passed from the nursery through a sliding window to the examination room. A demonstration room will be provided for the instruction of mothers in the care of the child.

The premature nursery has a fully air-conditioned, humidified and mechanically controlled system of heating and ventilation. All other wards, lavatories, service rooms and case room suites are ventilated by exhaust.

The observation suite is self-contained and separate from other parts of the hospital. It, too, is laid out on the cubicle system.

Basement

The building is connected to the existing hospital by a concrete tunnel. Adequate accommodation is provided for storage, wet and dry soiled linen and mechanical equipment.

Main Floor

The entrance is so arranged that ambulances or taxis may drive up to the door under a concrete porte-cochere. The dignified reception hall will be panelled in mahogany and have a decorated plaster ceiling. The admitting office, lying off the reception hall, connects with a preparation room, which also opens into an emergency case room. General ward accommodation, in three and five-bed wards, is found on this floor, as is also a nursery and the observation wards.

The building is serviced by two elevators, with double entrances, one elevator for passengers and the other for service use.

Upper Floors

The first floor is laid out for semi-private wards and nurseries with the usual services. Each ward has its own lavatory and toilet, bed-pan washing facilities and closets.

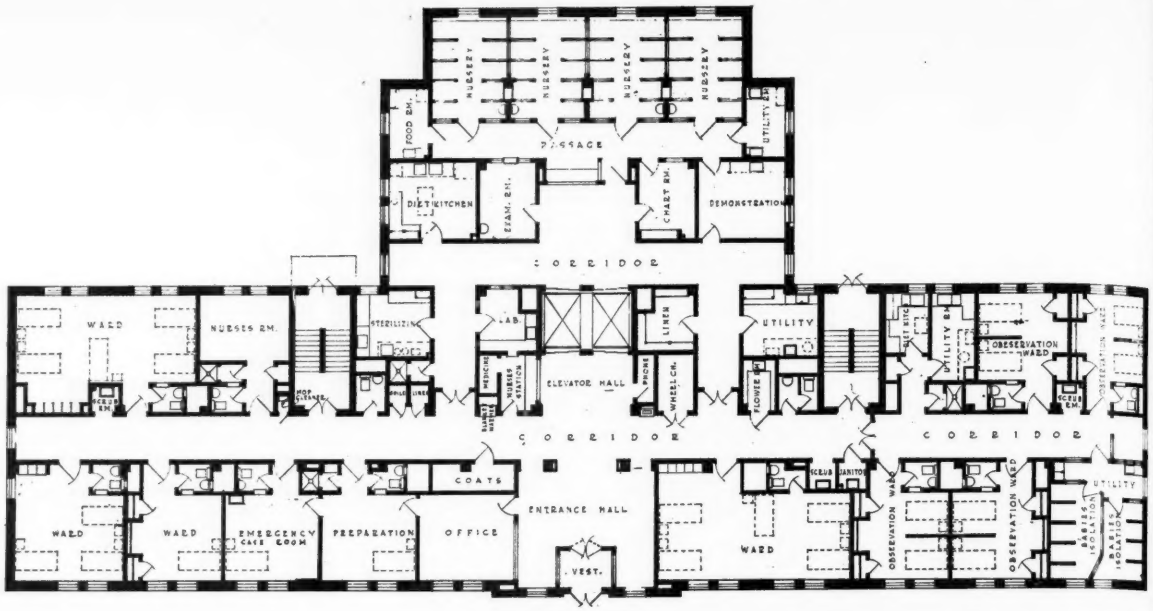
The second floor is planned for private ward cases and nurseries with the usual services. The wards on these two floors are of the same size. A semi-private ward may be converted into a private ward by removing one bed and, vice versa, a private ward can be made into a semi-private ward by adding a bed.

Third Floor

This floor is designed for operating services. There are four labour rooms with seven beds, two case rooms, with sterilizing and scrub rooms connected, and an operating room with the necessary facilities. Nurses' work rooms and sterilizing rooms are conveniently located and a doctors' suite with rest room, sitting room, toilet and shower is provided. This floor is completely soundproofed, as are all corridors, nurseries and service rooms. Enclosed fire escapes and service stairs serve all floors.

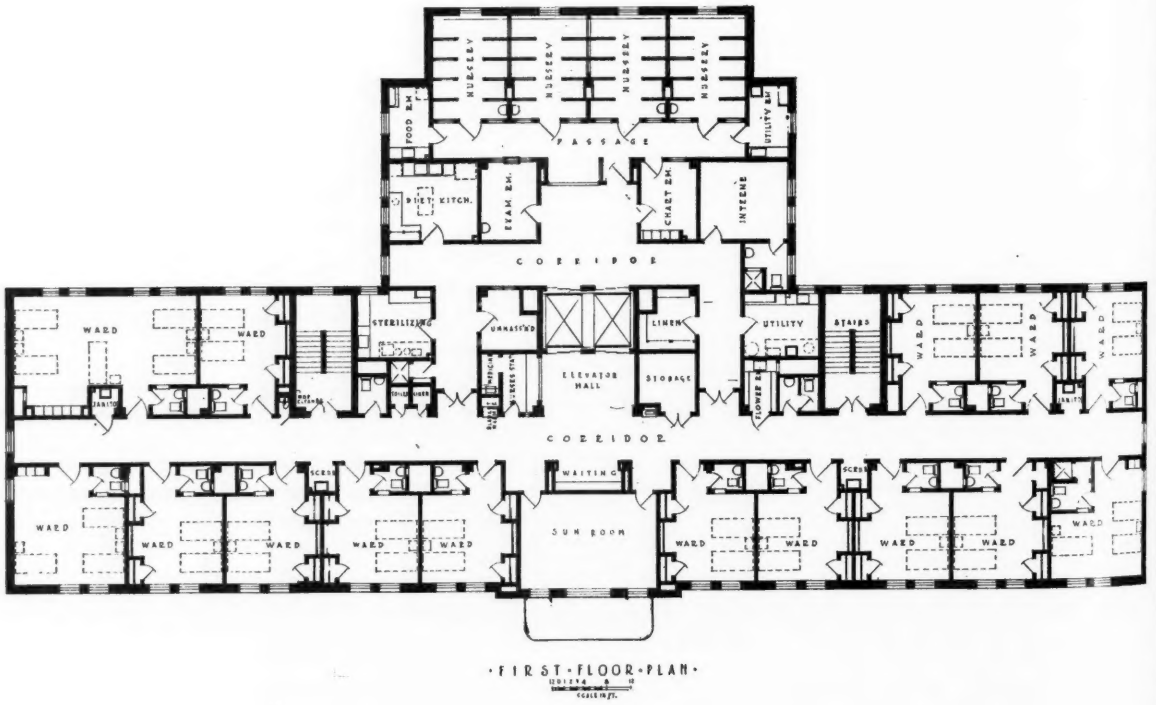
Modern electrical equipment is being installed, including doctors' and nurses' paging systems, patients' call and dictaphone service from the bed to nurses' station.

Heating is provided by low-pres-



·GROUND·FLOOR·PLAN·

(Note emergency suite, observation wards and isolation nurseries)

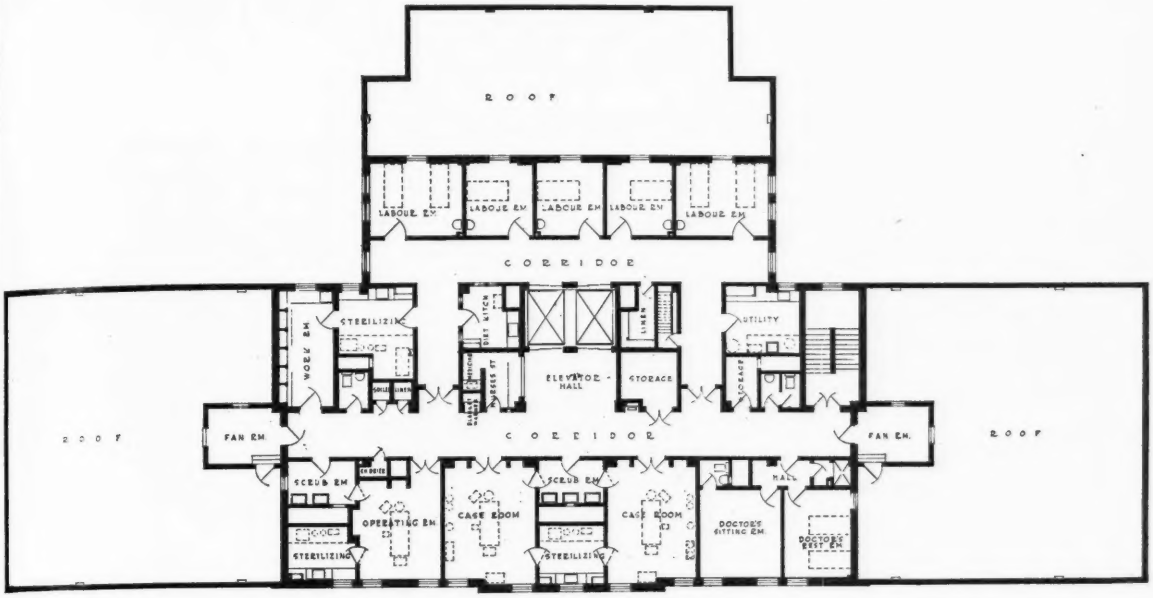


·FIRST·FLOOR·PLAN·

(This floor is for two and three-bed rooms with one five-bed ward. Each floor has its own nursery. Note the closing off of the nursery, the toilet for each room, the corridor scrub basins and the waiting alcove. The second floor has large private rooms and is of identical layout).

sure steam from the hospital's power plant, reduced in this unit from the high pressure mains. Automatic heat control is provided to case rooms, operating rooms and nurseries. All hot water lines to showers baths are controlled separately to avoid scalding.

The plans and specifications were prepared under the direction of H. Whittaker, Provincial Government Architect.



THIRD FLOOR PLAN

(Labour rooms are together on one side and case and operating rooms on the other side. This is better from the viewpoint of functional efficiency. Note adequacy of sterilizing equipment, also the doctors' rest room with freedom from noise).

Ontario Plan Purchases Building for Central Office

The Plan for Hospital Care in Ontario, operated by the Ontario Hospital Association, has purchased a fine office building at 1108 Bay Street, below Bloor, to permit it to centralize its Toronto offices in one building. This building should meet the requirements of the Toronto office for some time to come. The problem is to take possession, for new rental regulations effective during the period of negotiations have made it more difficult for owners to occupy their own property.

This Plan now has a staff of 129 people. Total income for 1944 exceeded one and three-quarter millions of dollars and the present income is at a rate exceeding two millions a year. The number of participants as at January 31st stood at 380,814. This is indeed a creditable record for just under four years of operation. Enrolment would undoubtedly have been still greater had it been possible to obtain qualified staff to meet the requests for organization in a number of cities and smaller centres. At the present time the increased enrolment in many industries and areas is being offset to a certain extent by curtailment of employment in certain war industries.

Of course many of those formerly employed in plants with Blue Cross membership are encouraging participation on the part of their fellow employees in other activities where they are now employed. The Plan has permitted these individuals to retain their membership. It is costing the Plan more to retain them, both in administration cost and in the fact that their utilization of hospital care is higher; however, they are proving good missionaries in other locations.

Manitoba Devises Plan to Meet Unpaid Accident Bills

Attorney-General J. O. McLenaghen has told the Manitoba legislature that every automobile owner in the province will be assessed a fee not to exceed one dollar annually to establish a fund for the payment of accident liabilities which cannot be collected in any other way. Legislation providing this "unsatisfied judgment" fund is to be introduced during the present session.

This fund is not to be a substitute for public liability insurance, it was explained. Persons not carrying such insurance and having an accident would be liable to be put off the road for all time. Hospitals, doctors and others who have so frequently borne the loss when neither side would pay or judgments were worthless will look with approval on this new legislation.

The Canadian Hospital Journal "Comes of Age"

TO those who have followed the progress of *The Canadian Hospital* for the past two decades, the fact that the journal has now reached its twenty-first birthday, and has therefore "come of age" will perhaps prove of more than passing interest.

Prior to the establishment of *The Canadian Hospital* in 1924 by Mr. Charles A. Edwards, no serious attempt had been made to publish a journal which would adequately serve the expanding hospital field in this country. Curiously enough, the initiative in this case came not from one well versed in hospital administration and health matters, but from a publisher, whose outlook reflected the problems of the advertising and business office.

C. A. Edwards

While this may appear to be a rather roundabout approach to the founding of a hospital magazine, it should be borne in mind that experience in the practical side of publishing, together with the ability to sell advertising, were assets of considerable value. Fortunately, many of those with a wide knowledge of hospital affairs gave a helping hand as the objectives of the new journal became known to our readers.

The middle twenties, with increasing prosperity, saw *The Canadian Hospital* firmly established. Soon, however, the big depression was to take its toll of advertising to the detriment of the journal. It reached a discouraging low in 1933, along with the majority of other business and class papers. The following year, however, showed an upward trend, and this has since continued without interruption.

During the year 1935 an important decision in the life of *The Canadian Hospital* was reached. The Canadian Hospital Council had by that time developed to a point where its executive committee considered it highly desirable to have an official journal in order to broaden its service to the hospitals of Canada. After the Secretary of the Council, Dr. Harvey Agnew, and Mr. Edwards had explored the situation thoroughly, a basis of agreement was reached whereby *The Canadian Hospital* became the official journal of the Council. This agreement became effective on April 1st, 1936. Under this arrangement the Canadian Hospital Council agreed to assume responsibility for the editorial department of the magazine. The late Mr. Leonard Shaw, administrator of the Saskatoon City Hospital, was appointed editor by the Council on a part-time basis. Mr. Shaw gave capable and faithful service in this work for about two years, when he moved to Chicago to become Assistant Secretary of the American Hospital Association. Dr. Harvey Agnew was then prevailed upon to accept this appointment along with his many other heavy duties. This has resulted in the development of a magazine which, despite a limited field, ranks with the best hospital magazine published.

The very happy relations resulting from this merging of interests continued over a period of five years, at the end of which time the Council, according to the agreement, had the privilege of exercising an option to purchase the journal. As an expression of his goodwill towards the Council and with the welfare of the hospitals at heart, Mr. Edwards offered to give the publishing rights of *The Canadian Hospital* to the Canadian Hospital Council. This very generous gift, which was deeply appreciated, was accepted at a meeting of the Council held in Montreal in September, 1941. Mr. Edwards has continued as business manager of *The Canadian Hospital.*

The growth of the magazine, in size and quality, during the past few years has been exceedingly gratifying. This has been due to the fine editorial direction of Dr. Agnew and to the faithful and co-operative services of Mr. Edwards; to the splendid support of those actively associated with the Council; to our large and enthusiastic body of readers; and to the many loyal and generous users of advertising space. During the twelve months ending December 31st, 1944, we printed a total of 980 pages, and over 400 engravings were used to illustrate articles. The actual cost of producing and mailing the twelve monthly copies to each of our readers was $9.85.

In observing this anniversary we would pay a special tribute to a number of our good friends who

(Continued on page 80)

The Use of the

STANDARD NOMENCLATURE OF DISEASE AND OPERATIONS

M. EDITH MORTLOCK, R.R.L.,
St. Michael's Hospital, Toronto.

MANY of our audience are familiar with the Standard Nomenclature of Disease and need no introduction to the book or its use. However, there are those whose primary reason for being present at this Convention is to gather new ideas.

You probably have heard the question asked many times: "Why is it necessary to have a Standard Nomenclature of Disease?" According to Dr. Jordan the purposes of a Standard Nomenclature of Disease are:

1. To bring order out of confusion in classification.

2. To permit clear thinking in the nature of disease and its manifestations by classifying according to location and cause.

3. To enable hospitals and other institutions and their staffs to improve their facilities for clinical research and their morbidity reports.

The book is made up of the Standard Nomenclature of Disease and Operations with a separate index for each and a Table of Eponymic Diseases. The terms in the index are arranged in alphabetical order and are, for the most part, according to the location of the disease. For example, "abscess of lung" is listed "lung, abscess of". It is not necessary to memorize any of the code numbers. Through constant use the more common codes become very familiar and the librarian will find herself remembering them without any effort.

To render the greatest assistance to her medical staff the record librarian should understand the scheme of classification thoroughly. The fundamental principle on which the Standard Nomenclature is based is that, when some cause acts on an organ or tissue, disease is produced. Hence, when we speak of pulmonary tuberculosis we know that the lung has been infected by the tubercle bacillus. From this fact is derived the code number which consists of the topographic classification or site of the disease and the etiologic classification or cause of the disorder. The code must contain six digits, the first three to the left of the hyphen representing the anatomic site and the three to the right of the hyphen describing the etiologic agent.

All diseases cannot be confined to one organ of the body. When this is not possible the site of the disease must be considered as the body as a whole, which is the first system listed, the anatomic code being 000. System 000 includes the mind 00, the body as a whole 01 and the regions 02. Examples of diseases listed under body as a whole 01 are influenza, rheumatic fever, small-pox, typhoid, etc.

There are some diseases which affect more than one anatomical system. Those parts of the body which are associated with more than one system are classified under *regions*, the anatomic code of which is 02. The leg is a region due to the fact that it is associated with the muscular system, the nervous system and the hemic and lymphatic systems. Other regions are the shoulder, abdomen, head, arm, etc.

A similar system of numbering the causes of disease makes up the second part of the code (etiologic classification). For instance, 100 is the code for infection, generally or unspecified, while 101 is a specific infection, the pneumococcus. Similarly, the code for poisoning generally is 300; 320 is the code for poisoning due to an alkali generally, but 325 is poisoning by a specific alkali, which in this case is sodium hydroxide. For example, a burn of the hand due to sodium hydroxide would be coded 085-325.

The following are diagnoses, one from each system of the body, with their respective code numbers:

010-168	Influenza
110-390	Eczema
240-912	Osteoarthritis
361-190	Bronchopneumonia
410-516	Arteriosclerotic heart disease
501-702	Pernicious anaemia
687-615	Calculus in gallbladder
723-496	Foreign body in ureter
810-887	Adenocarcinoma of thyroid gland
930-y01	Grand mal (epilepsy)
x70-yxx	Deafness due to undetermined cause.

From these examples one can understand the general idea of classifying disease according to the *site* and to the *cause*.

We will just comment briefly on the principles involved in the Standard Nomenclature of Operations. The digits in the anatomic sites correspond exactly with those used in the Standard Nomenclature of Disease. The fundamental surgical procedures have been divided into nine main categories as follows:

—0	Incision
—1	Excision
—2	Amputation
—3	Introduction
—4	Endoscopy

Reprinted from the "Bulletin of the Canadian Association of Medical Record Librarians" of which Miss Mortlock is Editor. The address was given at the 1944 Convention of the Association.

—5 Repair
—6 Destruction
—7 Suture
—8 Manipulation.

For example excision of a steatoma is coded 151-11, the 11 denoting local incision of the lesion. The code for appendectomy is 661-12, the 12 specifying complete or total excision of an organ. Similarly, for a partial or subtotal gastrectomy the code is 640-13, the 13 being the number given to a partial or subtotal excision of an organ.

This is a brief outline of the principle used in classifying diseases. Time does not permit going into further detail and the cardiac and obstetric classifications, as well as the eponymus have not been mentioned. However, I cannot stress too strongly the fact that to use the Standard Nomenclature successfully the record librarian should understand its scheme of classification thoroughly. Likewise she should become familiar with the foot-notes and directions as given in the book. She should be most cautious not to alter terms or code numbers.

An Appraisal of the "Standard Nomenclature"

By CHARLOTTE STUART,
Medical Record Librarian Student, St. Michael's Hospital, Toronto.

LET us begin by discussing "disapproval" since this may be disposed of quickly. There is no logical nor substantial argument against *Standard Nomenclature of Disease and Operations*. It may be said that it requires knowledge and skill to use it—but training is available in approved schools, and we should bear in mind that some record librarians have set up the system through their own efforts. Thus it is proven that the task is not impossible. Secondly, it may be argued that the system makes more demands on the physician. However, the returns directly benefiting the medical staff far over-balance the effort.

For a number of years those concerned with research and statistics have felt a great need for a common or unified nomenclature. *The Standard Nomenclature of Disease and Operations* has fulfilled that need more satisfactorily than any of the numerous systems. In 1928 a "Conference on Nomenclature and Disease" was held in New York, and as a result, the "Organization of National Conference on Nomenclature of Disease" was formed. The Commonwealth Fund was responsible for defraying half the cost of the work and national health associations participated in the construction by generous financial support. The basic plan was adopted officially in 1930 under the direction of the Executive Secretary, Dr. H. B. Logie. In 1937 the American Medical Association assumed the responsibility for further development and periodic revision. The 1942 edition of *Standard Nomenclature of Disease and Operations* is the product of this Association, which was aided by interested organizations and institutions.

The Standard Nomenclature of Disease and Operations is published by the American Medical Association, 535 North Dearborn St., Chicago.

The plan of the *Nomenclature* should be clearly in mind before we continue to discuss its many advantages. It is usually referred to as a dual classification, that is, each disease is described by both its anatomical location and by its etiology. The code for the site is placed at the left of a dividing hyphen and the code for the cause at the right. There are eleven major anatomical divisions and thirteen primary etiological categories. These form the first number or basis for the codes which usually consist of three digits on each side, but fine distinctions in either part may require the use of four to six digits. *The Nomenclature of Operations* is correlated with that of disease since the same anatomical code is used on the left side. The type of operation is signified by a code on the right of the hyphen.

For example: 661-1XO is the code for Chronic Appendicitis, and 661-12 is the code for excision of appendix or Appendectomy.

The Nomenclature definitely promotes *uniformity in terminology*. At the same time it stimulates clear thinking on the exact nature and cause of the disease. It has brought order and accuracy to many record departments whose cross-index system has been changed and altered by individual choice, without scientific plan. Everyone will agree that the record department using the *Standard Nomenclature of Disease and Operations* will be one of higher standard. The record librarian with these files at her disposal will be able to compile statistics with minimum effort.

Doctors and interns will have high regard for the immediate and accurate response to various requests. Whether they would like histories of a particular "type" of carcinoma or whether they would like carcinoma cases of a specific "site" or organ, will not confuse the record librarian. They are quickly and easily available.

Many hospitals are at present feeling the need of a more complete nomenclature. During these days of marked increase in hospital activities, the nomenclature in use may no longer meet the requirements of the growing hospital. The present nomenclature in use may be inadequate or too obscure for research or teaching purposes. Recent survey has shown that a great majority of hospitals, particularly the smaller ones, have not yet adopted any of the various nomenclatures. These hospitals are not conducive to the advancement

(Continued on page 78)

Grace Hospital, Windsor, Opens New North Wing

By BRIGADIER ALICE BRETT,
Superintendent.

A SOURCE of great pride to all those connected with the Grace Hospital at Windsor, Ontario, is the impressive new North Wing, officially opened by His Honour the Lieutenant-Governor of Ontario and Mrs. Matthews. The new building, with accommodation for 70 beds and 53 bassinets, contains one of the most advanced systems of obstetrical care, and both mothers and babies will receive the very best and latest facilities and treatment. As well as the increased bed capacity, the new wing contains diet kitchens, dining rooms for the nursing and general staffs, a library and lounge rooms, and three delivery rooms. It is a three-storey structure of ultra-modern design and architecture.

The Top Floor

The top floor comprises a two-bed admitting room and the three labour rooms and three well-equipped delivery rooms, including electrically-heated cots and other equipment, a doctors' sitting room, shower and bedroom. Another innovation is the Fathers' room, complete with pleasant furnishings and a radio, where the "daddies-to-be" may pace the floor or wait in comfortable suspense for the arrival of the august young guest. The isolation unit is also situated on this floor, as well as three and four-bed wards.

Nurseries

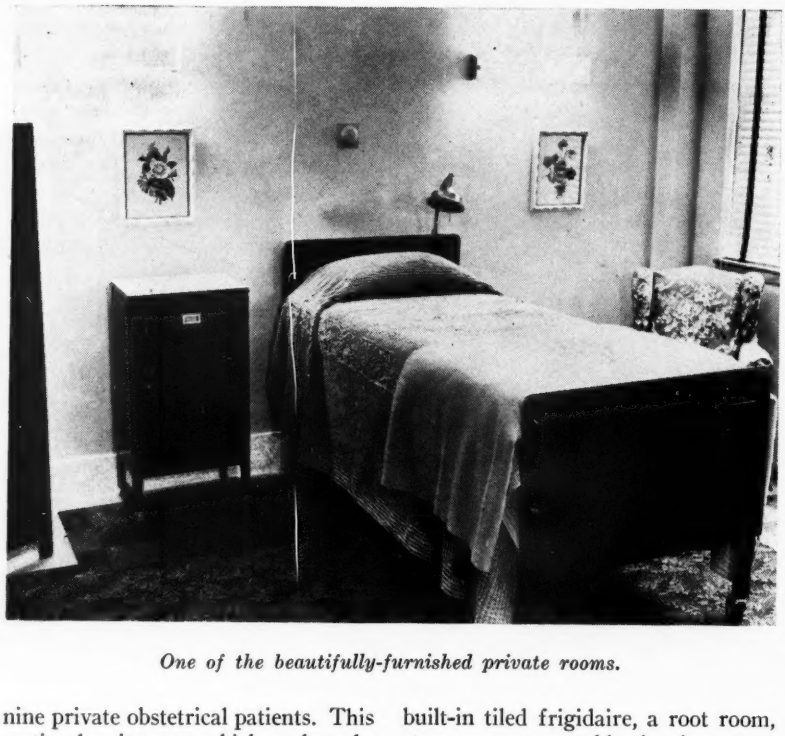
The special nurseries are divided into cubicles, four by four feet, encased in metal and glass. Only nurses are permitted near the babies, the doctors not even being allowed to enter the room. When a doctor examines a child of one of his patients, he enters through an adjoining room, scrubs up, and then has the baby passed to him through a wicket. Visitors see the new babies only through a glass square and they request the baby desired through a filtered speaking system into the nursery. In this way, and through the use of special germicidal lamps, it is expected that infection will be reduced to a minimum. There are also the usual working units of diet kitchen, completely fitted with monel metal sinks and equipment and electric food carriers, etc. A dumb-waiter is also provided, as well as wash rooms, sterilizing rooms, utility rooms, etc.

Second Floor

The second floor contains private and semi-private rooms. A large cubicle nursery is also provided on this floor, as well as a specially constructed three-cubicle premature nursery and an isolation unit. The usual working units are included.

The ground floor is in two sections, with seventeen semi-private beds for surgical cases and with the "T" part of the floor reserved for

Above: View of the Hospital showing the new wing at right.



One of the beautifully-furnished private rooms.

nine private obstetrical patients. This section has its own cubicle and working units.

The floor contains several de luxe rooms on whose furnishing particular care has been lavished. However, the hospital takes a justifiable pride in the furnishings of all the rooms in this new wing. Dark maple furniture is used throughout, and overbeds and bedside tables are topped with formica. A pretty and restful colour scheme, with soft green predominating, enhances the charm of the rooms. Venetian blinds are used in all rooms, and the floor is covered with an attractive green and black asphalt tiling.

Basement

The basement houses the superindent's dining room, staff dining room and students' dining room. There is certainly nothing "institutional" about the decoration of these rooms. For instance, the staff dining-room is painted in coral with blue-topped tables and white leather chairs, large mirrors, lovely pictures and pretty drapes. The students' dining-room is equally attractive in blue, with black-topped tables and red leather chairs, huge mirrors and lovely pictures and drapes.

The kitchen is a dietitian's and cook's paradise. It is large and well-ventilated and red-tiled from floor to ceiling. There is a dietitian's office, built-in tiled frigidaire, a root room, store rooms, vegetable-cleaning room, dish-washing room and special little teaching kitchenette. Electric food carriers are at the entrance to each dining-room. There are also monel metal shelves for desserts. The kitchen is equipped with the most modern aids in food preparation, and three tea and coffee urns provide these beverages in three minutes' time. Distilled cooled water is on hand at all times in the dining room.

The superintendent's dining-room is beautifully furnished with an ornate oak suite, an oriental rug almost completely covering the entire room and interesting oil paintings.

A sitting room with double-decker rest room for night nurses on their hours off duty is also provided, along with wash rooms.

An attractively furnished and well-stocked library—the gift of the Gracia Club—is an added feature. A book-waggon enables patients to make their selection from the books brought around to their bedsides.

The furnishing of the new wing has been more or less a community project. Clubs and associations have taken a keen interest—the hospital staff, the ladies' auxiliary, the nurses' alumnae, the members of the medical staff and a number of other friends of the hospital.

During the course of his opening address His Honour the Lieutenant-Governor stated that he wished to donate a room in the hospital, to be called the Maude Matthews Room.

The attractive staff dining room.

Modern Hospital Formally Opened at Raymond, Alberta

A fine new $50,000 municipal hospital was opened on February 2nd at Raymond, Alberta. Guests for the occasion included the deputy minister of health, Dr. M. R. Bow, and Mr. E. E. Maxwell, supervisor of hospitals. The hospital has a capacity of 21 beds.

Government Aid for Hospital Construction Planned for U.S.

A BILL has been introduced in the United States senate which is designed to provide federal funds to assist in the expansion of hospitals throughout the United States. This measure was prepared after much work on the part of the Council on Government Relations of the American Hospital Association and the Joint Committee of the three national hospital associations. The Bill is known as Senate Bill S 191, and is being referred to as the "Hospital Construction Act". We are indebted to Father Alphonse M. Schwitalla, S.J., writing in *Hospital Progress* for the details from which the following summary has been made.

The purpose of the measure is to assist the several states (a) to inventory their existing hospitals; to survey the need for added construction; to develop programmes of construction; and (b) to construct public and other non-profit hospitals in accordance with such programmes.

The term "hospital" is understood to include public health centres and general, tuberculosis, mental, chronic disease and other types of hospitals, and related facilities, such as laboratories, out - patient departments, nurses' home and training facilities, and central service facilities. Hospitals furnishing primarily domiciliary care are not included. In order to make the inventory, survey the need and develop programmes of construction, the sum of $5,000,000 and for assistance in construction the sum of $100,000,000 has been authorized for the year ending June 30th, 1946. An additional sum of $5,000,000 has been authorized to assist the official bodies in the various states to meet their administrative expenses in carrying out the approved plans.

In each state there is to be a single state agency which shall carry out the purposes of the appropriation. Also there must be a state advisory council, which must include representatives both of the state agencies concerned with the operation, construction and utilization of hospitals and also representatives of non-governmental organizations engaged in the same activity. This agency must be given adequate authority. Its construction programme must be in accordance with standards prescribed by the Surgeon General.

A Federal Advisory Council is to be set up with the Surgeon General, U.S.P.H.S., as chairman and eight members appointed by the Federal Security Administrator. These eight members must be recognized authorities in the hospital and health field, the majority being experts in hospital operation. Programmes must be approved by this body, which will take as its basis of approval the adequacy of the plan to provide the necessary physical facilities for ensuring hospital, clinic and similar services to all the people of the state.

At the opening of the new North Wing, Grace Hospital, Windsor. The official party includes Mrs. Matthews, the Hon. Albert Matthews, Lieut.-Governor of Ontario, and Dr. Farquhar MacLennan, medical superintendent of the hospital.

National Health Survey Report Now Available

The extensive study of health personnel and facilties in Canada made by the government-sponsored Canadian Medical Procurement and Assignment Board is now available in one printed volume issued by the King's Printer, Ottawa. This study was made with the co-operation of the Canadian Medical Association, the Canadian Nurses' Association, the Canadian Hospital Council, the Dominion Council of Health, the Canadian Dental Association, the National Research Council, the nine medical schools and others.

Undertaken two years ago, this study provides the most complete review yet prepared of our health services in Canada. Without question it will be a valuable guide and reference source for many years to come.

Minimum Wage Regulations in Saskatchewan to be Revised

The voluntary hospitals in Saskatchewan have been concerned because the new Minimum Wage Act passed in that province at the last session of the legislature placed the voluntary hospitals under the Minimum Wage Act but did not so include the municipal hospitals.

This matter has been discussed by the Executive of the Saskatchewan Hospital Association in conference with members of the Provincial Cabinet and assurance has been given that this situation will be corrected. Apparently the discrimination had not been noticed in the wording of the Act and assurance has been given that a new Order would be issued by which either all or no hospitals would be affected by the Minimum Wage Act.

Britain Guards Health Now

---and Plans for the Future

By H. O. HOFMEYER, M.D.,
Medical Liaison Officer, British Commonwealth Scientific Office, Washington.

WE who know conditions in Britain intimately are filled with admiration of the way in which the British health services have responded to the supreme test of a long war. It will be remembered that *in 1919 the Ministry of Health was created by Parliament* to take responsibility for the general supervision of all matters relating to the public health, the sanitary service, working class houses, national health insurance, etc. The Scottish Board of Health performs a similar function in Scotland. Other Government departments control special aspects of the health service. For instance, the Ministry of Labour supervises health in industrial workers; the Ministry of Fuel and Power, the miners; the Ministry of War Transport, conditions aboard merchant ships; the Board of Education, medical inspection of school children; Ministry of Food, wartime nutrition. The British Medical Association, like your great American Medical Association, is a voluntary organization which is recognized as the negotiating instrument of the medical profession. The Minister of Health is a member of the Medical Research Council which is a committee of the privy-council responsible for Medical Research.

Emergency Hospital Scheme

Britain began the war with more than 3,000 hospitals. In 1939 the Civilian Defence Act was passed by parliament and this gave the Ministry of Health the Emergency Hospital Scheme which was created to deal practically and efficiently with war-casualties and cases of illness among evacuees. It resulted in a unified emergency hospital and laboratory service. Before the war the existing hospitals had three hundred and seventy thousand beds which were wholly in use and it was then estimated that not less than three hundred thousand hospital beds should be made available for civilian casualties. One hundred thousand of these beds were provided by introducing extra beds into existing hospital premises and the remainder were added by a complete programme of Hutment Annexes. Much of the accommodation in Hutment hospitals and County Council institutions have been turned over to the American and Canadian Forces in Britain. For acute emergency, buildings such as the dormitories of boarding schools, or local hotels, were ear-marked as reserve hospitals. Preparatory plumbing work was performed in such buildings without interfering with their normal use.

Organization

The Emergency Hospital Scheme divided England into 11 regions and Scotland into 5 regions, for purposes of civilian defence. The London region was divided into 10 sections radiating from an apex in the centre to a base in the home counties, each under a group officer. Hospitals were classified on a regional basis with an evacuation plan:

1. In vulnerable areas they were regarded as casualty clearing centres from which their patients were evacuated to less dangerous districts.

2. In reception areas hospitals cleared part of their buildings for the Emergency Hospital Scheme.

As regards finance, the Ministry pays the full cost of performing emergency medical service work for air-raid casualties, service casualties, Civilian Defence workers, and members of the home guard or merchant navy injured in the course of duty. Over 70 special treatment centres were set up to provide specialist attention for those who need more than the essential facilities for care, treatment or rehabilitation.

Transport

Transport is taken care of by the *Inter-Hospital Ambulance Scheme* and casualty evacuation trains. This organization has worked remarkably smoothly and efficiently in spite of the fact that more than 500 hospitals had been bombed by the end of 1943. After D-day plus six, 8,000 flying bombs were launched during the following eighty days at London. Some 29 per cent of these pierced the defences, killed 5,000, injured 15,000, wrecked a million houses and one hundred hospitals. These hospitals include the famous Royal Free, St. Thomas, and the Moorfield Eye Hospital. In one heavy air raid on London in the spring of 1941 numerous casualties had been operated upon or otherwise treated and evacuated to outer hospitals by the next afternoon. This system has given rise to *a new conception of hospital treatment* and recently the Minister of Health has indicated in the House of Commons that the Government proposed to base its post-war hospital planning on the following principles:

(a) *A comprehensive regionalized system provided by the major local authorities in co-operation with the voluntary bodies, supplemented by specialized services,* also organized in areas.

(b) Financial backing by the Government.

Supplies and Personnel

The Minister of Health is responsible for the organization of supplies such as dressings, bandages, furni-

From an Address at the International Session during the Cleveland Convention of the American Hospital Association in October, 1944.

ture, apparatus, drugs, blood transfusion, cooking and transportation.

The machinery for calling up doctors from civilian practice was worked out in detail before the war through local and central committees of the medical profession, and 2,000 doctors were earmarked for the E.M.S. The ministry has wide powers and can call up male doctors up to the age of 46 or female doctors under the age of 31 under the *National Service Act.* It can also direct them to take up particular types of work or to transfer from one hospital to another in an emergency. Some 800 alien doctors have been admitted temporarily to the medical register. Another order has authorized the inclusion of doctors qualified to practise in Canada or the United States. A Civil Nursing Reserve was formed which brought retired nurses back to the profession. Recruitment of nurses was stimulated and the Ministry of Labour gave the profession high priority among forms of war work open to women who register under the National Service Act.

Air Raid Precaution

The Emergency Medical Service also provides the ambulances for conveying the injured to hospitals and first aid posts. In England there are about 13,000 stretcher-carrying ambulances with an additional 10,000 cars for "sitting cases". In London there are 366 fixed and 206 mobile first aid posts. All precautions have been taken against gas attacks, such as the issue of respirators, and cleansing sections have been attached to first aid posts with mobile units.

Shelters

In 1940 shelters had not been constructed for dormitory use. However, as the war went on, bunks were installed and medical aid posts, staffed by nurses and a doctor, were set up in every shelter occupied by more than 500 sleepers. At present there are bunks for more than half a million people. The homeless have also been taken care of and there are over 20,000 first and second line rest centres in England and Wales with accommodations for more than 2½ million persons.

Child Health

All phases of wartime child care have been undertaken by the maternity and child welfare committees of the local authorities. By the end of 1941 more than 2½ million persons had been moved under Government evacuation and another half a million privately. It was very satisfying to everybody to find that these movements did not lead to a sharp rise in the incidence of infectious diseases.

Industrial Health

The original Factory Acts, which laid down elaborate requirements for the safety, health and welfare of industrial workers, were elaborated and extended to take care of wartime conditions.

General Health

The Registrar General's returns reflect an unusually excellent state of the public health in England and Wales. The birth rate is the highest since 1928. The death rate is lower than in 1941. The infantile mortality rates and the still-birth rates are the lowest on record. Sir Wilson Jameson, C.M.O., of the Ministry of Health in summing up his report stated, "A country could not produce figures of this kind if its health weer suffering materially at this time. So far the rate of infectious diseases has been normal, and with certain exceptions has been below average."

The "White Paper" on The National Health Service

There has been a great deal of heart searching and self examination in Great Britain in regard to future social development. As a result a number of new plans have been formulated, one of the most far reaching of which has been the White Paper on National Health Service published by the Ministry of Health and the Department of State for Scotland on February17, 1944. The White Paper represents the considered opinion of the Government and its proposals will be freely aired in parliament and discussions will be held with representatives of the medical profession, local authorities, voluntary hospitals, pharmacists, etc. It should not be confused with the *Beveridge Report* which is still in preparation. It does, however, aim at fulfillment of Assumption B of that report—"comprehensive health and rehabilitation services for all as a basis for comprehensive social insurance."

(Details of the White Paper provisions were given in the April, '44, issue of "Canadian Hospital, page 56).

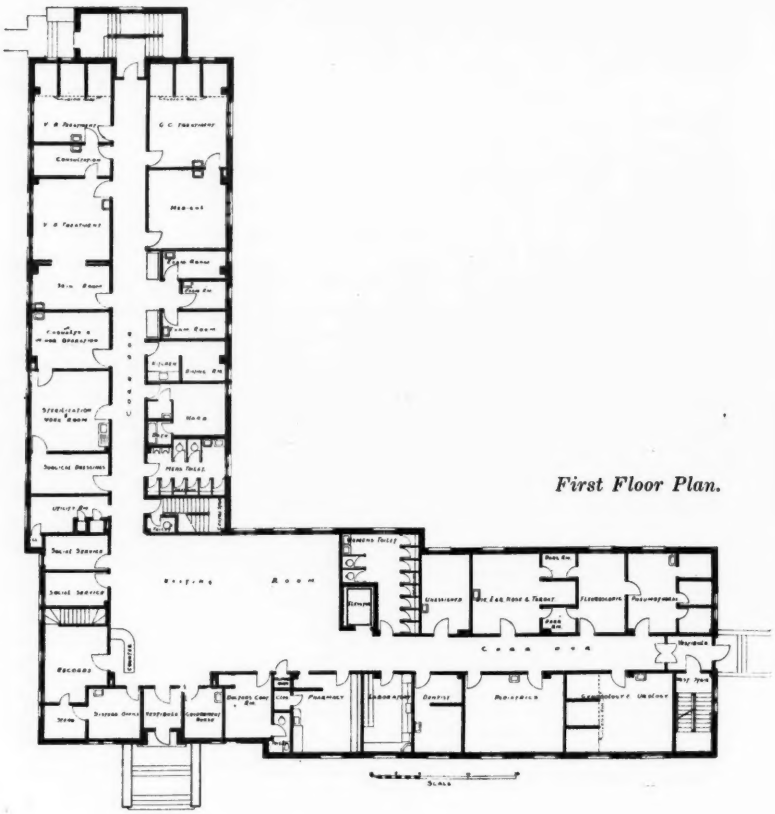
(Concluded on page 82)

Dumbarton Oaks Provisions for a Health Programme

Facilities for international medical and health programmes are provided in the proposed United Nations organization planned at Dumbarton Oaks. An Economic and Social Council, to be a separate subsidiary to the main General Council, will be able to go into the field of international economic and social co-operation on a much broader basis than in the old League of Nations. The General Council would have the power to elect eighteen countries whose representatives would sit on this Economic and Social Council for three year terms. The number was limited to eighteen so as to create a workable body. On the Economic and Social Council each country would have one vote and its decisions would be made by simple majority. All the nations elected might be small nations, though that is unlikely.

The Economic and Social Council would recommend courses of action to the General Assembly. Decisions of the Economic and Social Council would not become laws regulating international commerce, immigration and emigration or sanitary, labour and living conditions in any country. It could recommend courses of action to the General Assembly or provide information to the Security Council on international conditions affecting the peace of the world. Present independent social and economic agencies would take part on appropriate commissions. For instance, the UNRRA and the International Labour organization would come under the social and humanitarian commission. For the first time it is proposed to create a body to look at the whole world, see what goes on in living conditions, labour and commerce, and recommend what might be done to keep nations from causing war.

—J.A.M.A., 126:904.



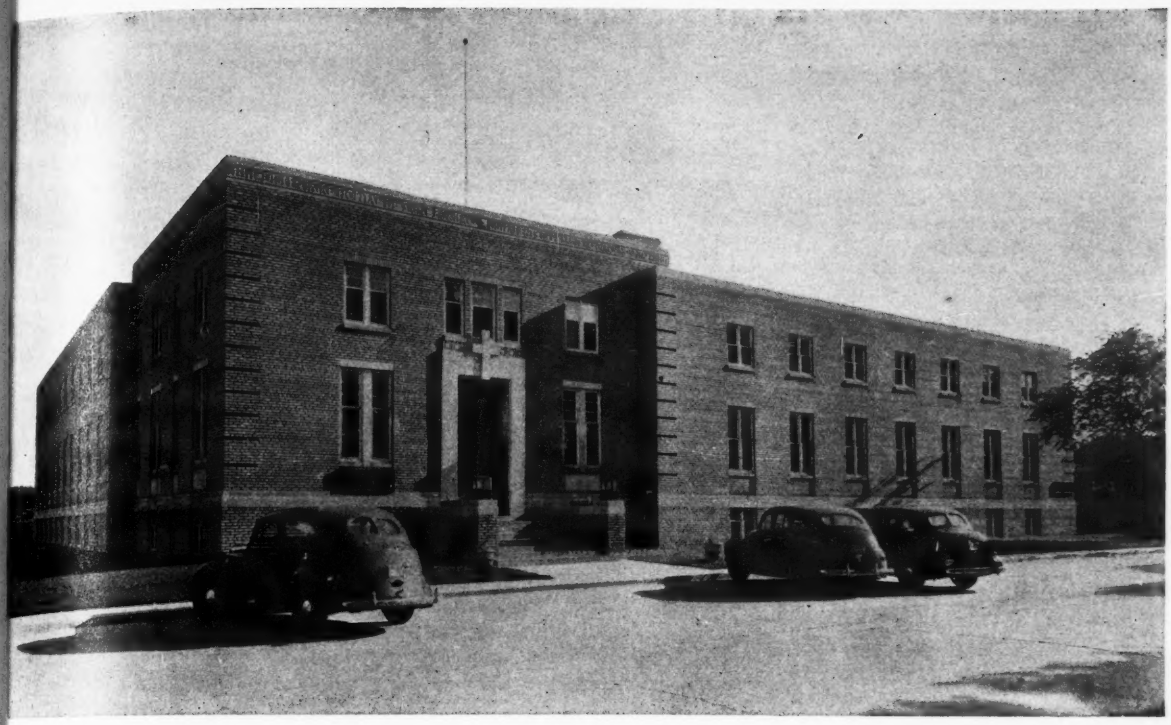
First Floor Plan.

Outpatients' Department,

St. Boniface Hospital,

St. Boniface, Man.

Basement Plan.



The Outpatient Department, St. Boniface Hospital.

Professional Men Under Section of Labour Code

OF interest to all professional workers employed in industry is the announcement of February 13th by Labour Minister Mitchell that professional workers would be placed under a special section of the Federal Labour Code for a period of at least six months, after which their position will be reviewed by the National Labour Relations Board.

Various groups of professional workers, including engineers, architects and chemists, recently appealed to the board to be excluded from the collective bargaining terms of the code. They maintained that if a union obtained the right to represent workers in a plant it should not speak for the professional workers. Labour organizations opposed this view. When the code was first introduced the professional groups were for a time temporarily classed as confidential workers, who are not subject to the collective bargaining terms of the code.

The clause under which they now are placed provides for dealing with employees of a particular craft separately and not grouping them with the other employees in union representation.

On their last appearance before the board the professional groups proposed the creation of an entirely separate code and organization of labour relations board to deal with the professional worker. The national board in its report to the Minister said that such a plan would involve substantial expenditures.

Minister Approves Hospital at Crow's Nest Pass

The Alberta Minister of Health has approved the construction of a municipal hospital in the Crow's Nest Pass half-way between Blairmore and Coleman at an estimated cost of $185,000. The building would provide 60 beds. Meech and Meech, Lethbridge, will be the architects.

Hospital to Appeal Collective Bargaining Vote

Mr. Chester J. Decker, general superintendent of the Toronto General Hospital, has stated that the hospital will appeal the bargaining vote taken at the hospital in February on the ground that illegal tactics and coercion had been practised. This appeal will be taken to the Ontario Board and, if necessary, to the National Labour Relations Board at Ottawa.

In the vote 347 ballots were cast by the 551 employees eligible to vote. Nurses and professional staff were not included. There were 304 votes cast in favour of having collective bargaining through Local 204 of the Building Service Employees' International Union, A.F. of L. Labour officials state that this is the beginning of a drive to organize all service employees in Toronto hospitals.

According to the law, for three days prior to ballotting neither interested party is permitted to campaign for its own cause. Apparently this was violated by at least one employee, a leader in union organizing activities.

Obiter Dicta

Manitoba Adopts Standard Nomenclature

THE Report on "Hospitals in Manitoba" released last autumn (See *Canadian Hospital* for December) had so many worthwhile features that one minor but potentially mighty recommendation has received but little outside notice. That was the recommendation that the "Standard Nomenclature of Disease and Operations" be adopted by the Manitoba Hospital Council and that it be compulsory for all hospitals. If adopted, this recommendation will make Manitoba the first province to take this forward step.

Already the Canadian Hospital Council and the Canadian Medical Association have approved this nomenclature which was developed some thirteen years ago by a joint committee representing the leading national medical, hospital and public health organizations in the United States. The primary purpose was to end once and for all the confusion in medical literature resulting from a multiplicity of terms and filing methods for the same clinical entity. Most physicians use terms drawn from several nomenclatures, frequently in the same article or address. The "Standard Nomenclature" lends itself unusually well to intelligent filing, as listing is based on *cause* as well as site. Already most of the leading hospitals on this continent have adopted the Standard system and initial steps have been taken towards its adoption abroad. As time goes on students and interns trained in the use of these terms will become the lecturers and the writers of books for the next generation, thus further clarifying the picture.

The question has been raised, "How can smaller hospitals comply with an official nomenclature?" Obviously the problem differs from that in larger hospitals. The guide book does seem a bit complicated at first, partly because of the use of figures for numerical indexing; the system, however, permits varying degrees of simplification. Methods of condensation and simplification have been developed primarily for the smaller hospital. Basic titles have been selected as a guide in this simplification. No new or expensive equipment is required; however, it is essential to have cards adapted for Standard filing. The Canadian Association of Medical Record Librarians, through its bulletin and at its conventions, has done much to promote a better knowledge of this system.

If there is a full or part time medical record librarian, it would be advisable to arrange for her to take a course in the use of the Standard system. In the case of Manitoba it is hoped that the Government will be able to arrange intensive courses for the training of part time or full time librarians in this method. This would be a great help. Of course, for the proper training of a medical record librarian a full course of at least one year is generally considered essential. At the present time, however, we believe that there is only one hospital in Canada conducting a school of this nature and that is St. Michael's Hospital in Toronto.

For a time the busy medical man is likely to continue using the terms to which he has become accustomed in recording operations or entering diagnoses on discharge. For filing purposes the librarian should be authorized to translate these if necessary into "Standard" terminology. For instance "peptic ulcer" would become "640-951 ulcer of the stomach" or "651-951 duodenal ulcer". To do this intelligently it will be necessary to have information respecting both site and cause, but the result is worth the effort. Gradually the use of approved terms and appre-

ciation of the filing methods will develop, particularly as younger men trained in the method during their internship days join the staff.

Hospitals too small to employ a librarian will have more difficulty. A member of the medical staff should be named as chairman of the medical records committee and in very small hospitals he may need to take considerable personal responsibility in setting up a satisfactory records system. However, if at all possible, some person on the hospital staff interested in that type of work—the bookkeeper, for instance, a Sister or a graduate nurse—should be assigned to this work on a part time basis, preferably after a period of training.

The Pan-American Movement

RECENT public references to the possibility of Canada's receiving an invitation to join the Pan-American Union indicate the growing importance of the inter-American relationship to all countries in the three Americas. The none-too-well veiled efforts of the Germans to gain control of the South American field during the past few decades, and now brazenly revealed by the Nazis, has stimulated increased interest in this movement on the part of the Latin-American countries, who see in the Pan-American movement a logical means of promoting their mutual welfare. Although there are indications that Canada would be welcomed in this circle, there are certain factors which would require careful consideration. Although she is an independent Dominion, Canada has a form of government different in some respects from those of the American republics and she has a relationship to other parts of the world not felt by her neighbours. With the future world position of the various nations not entirely clear, it is understandable why Ottawa does not seem to desire to make any statement at the present time nor to be drawn into any premature discussion of the Dumbarton Oaks proposals.

The Pan-American Union was really initiated in 1890 as the International Union of American Republics. Its present name was not adopted until 1910. Its basic purpose has been "to develop closer intellectual and commercial relations between the republics of the American continent and to promote international co-operation in every possible way". It is supported by quotas paid by the republics in proportion to population. The beautiful headquarters in Washington, however, is a gift from Andrew Carnegie. There are four official languages—English, Spanish, Portugese and French—monthly bulletins and other literature are published and the large Columbus Memorial Library houses a fine collection of books, maps and other works of rerefence.

Whether or not the Canadian government joins the Pan-American Union, the Inter-American Hospital Association and the A.H.A. Council on International Relations have done much already to bring the hospitals in the three Americas into closer contact. The three "Institutes" already held—Puerta Rica, Mexico City and Lima—have been most helpful, *Modern Hospital's* "El Libro del Hospital Moderno" has become widely known, articles have been published in the hospital journals of other countries, and already there has been much travel despite the abnormal present-day restrictions. We could learn much from our Latin-American neighbours.

"Chief Doctor of the Camps"

THERE is one doctor who must have a very marked sinking feeling by now. His name is on THE LIST—the official list compiled by the Russians of those who have been specifically named by the investigating committee as responsible for certain of the unbelievable atrocities and crimes perpetrated by the Germans on subject people and their property. One of the Committees has been investigating the crimes in Estonia and has listed the "hangmen" whom they will call strictly to account—and in Russian fashion—for these mass murders, torture and destruction of cultural institutions. On this ominous list appears the "Chief Doctor of the Camps, Dr. Bodmann".

It is obvious that German members of this humanitarian profession can be quite as atavistic as their monstrous lay associates. A Dr. Bochmann systematically poisoned sick inmates of his institution by injecting evipan. Under the satirical title, "The Flower of Germany", the noted Russian writer Ilya Ehrenburg* reviews some of the noble research studies of German doctors during this and the last war. Typhus lice were bred on Russians, Poles and Jews in order to obtain serum. There were special institutes in Riga and Lvov. In these cases the investigators but followed the practice of Professor Jurgens who conducted gigantic experiments on Russian prisoners back in 1916—before there was Naziism. His book, published in Berlin, is a cold-blooded recital of utterly inhuman experiments on helpless human "guinea-pigs". At about the same time a Doctor "G.O." injected the blood of typhus patients into 430 healthy Turko soldiers and civilians; of these 48 died. Actually these experiments on citizens of a country then an ally with Germany were of little value, as work of this nature had already been done in 1876 and again in 1909. In this present war the Germans selected a former lecturer at the Sorbonne University in Paris and opened his veins to see how hormones and secretory glands act when the blood is completely drained away. Another German, in order to gather material for a study of the effect of strangulation by hanging, had had 35 innocent persons hanged. Says Ehrenburg: "We must not forget, we must not allow ourselves to get soft-hearted. The country whose scientists torture human beings must be bridled; it must be put in a strait-jacket and its hands tied behind its back." We respect German medicine for what it was, but there is accumulating evidence that it is now but a cold and heartless science, not a profession dedicated to the alleviation of suffering irrespective of colour or race. Russian treatment may expedite a cure.

Those old lines from the "Mikado" may have uncontemplated significance:

"He's got 'em on the list—
and they'll none of 'em be missed."

Information Bulletin of the Embassy of U.S.S.R., Washington, for February 8, 1945.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

The Government have now issued the White Paper on local government. The subject is of particular importance as it touches the national life at so many points, especially in reference to the social services. This White Paper, therefore, calls for the especial study of those concerned for the future of the health and hospital services. There seems to be need for it.

Lately the *Lancet* has more than once had occasion to explain to its medical readers elementary principles of constitutional government. For example in the current issue (January 6th, 1945) an editorial note to a letter states:

> "Most certainly the medical profession should have a large share in building any new service, and an effective voice in its administration. But technical skill does not confer on its possessors the right to control services provided by the public for the public. Such services cannot be run by elected representatives of the medical profession, responsible only to the profession; for in a democracy control must ultimately rest with elected representatives of those who find the money—either locally through local authorities, centrally through Parliament, or both."

It is the local authorities to whom the medical profession take particular exception and in this they have had some active support from the voluntary hospitals.

Before putting forward their proposals the Government have had a number of discussions with interested bodies, but even now they state quite definitely that these proposals are not to be regarded as decisions. They are made public in the hope that it will be possible in the light of the discussion of them both in Parliament and elsewhere to introduce early legislation which will be largely agreed.

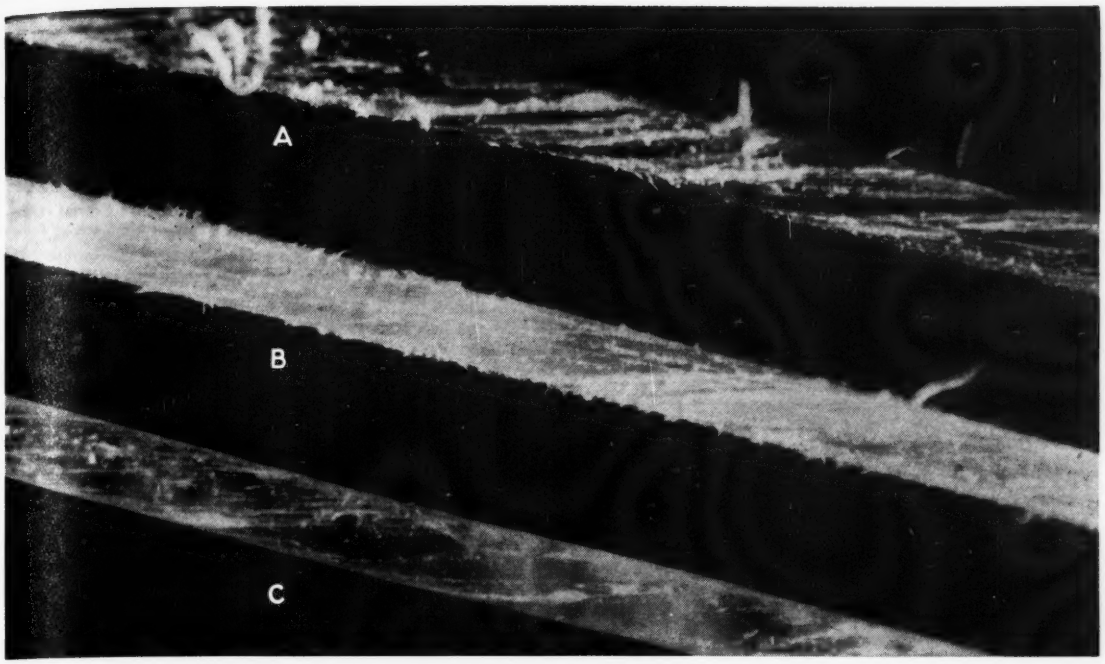
The first point made is "that local government in this country is a living organism capable of adaptation to meet new conditions". Through hundreds of years it has shown its ability to develop to meet the needs of the people. It is significant, however, that this White Paper does not cover the parish which is perhaps the oldest unit of local government. The tendency has been to develop larger areas and it is in this connection that the medical and hospital authorities have been pushing proposals. Upon this the Government remark that there is no general desire in local government circles for a disruption of the present system or any consensus of opinion as to what should replace it. Moreover the Government add that the making of a change of this magnitude, which would, by common consent, have to be preceded by a full dress inquiry would be a process occupying some years and would seriously delay the establishment of the new or extended housing, educational, health and other services which form part of the Government's programme.

Proceeding to enunciate principles for development, the Government state quite definitely that they are opposed to any general policy of centralizing services hitherto regarded as essentially local. Nor do they believe —and their belief is stated in words—"that a solution is to be found in the creation of regional authorities". A good many people have had experience of regions in connection with the organization of civil defence. Other departments including the Ministry of Health have followed on the same lines. The voluntary hospitals and the doctors thought that they saw in them a way of escape from their particular bugbear. There was very little in the way of constructive argument in favour of these particular areas. However, the Government have made their position quite clear. They believe it to be inexpedient to contemplate drastic innovations, such as the constitution of regional bodies, in reshaping the local government system to fit post-war needs. "They prefer to rely on the existing structure based on the county and county borough, with appropriate machinery, where necessary, for combined action." Something on a small scale is already in operation on these lines in the hospital world in dealing with infectious diseases.

Finance, of course, cannot be left out of account in dealing with these proposals. The arguments which take place on the subject are not dissimilar to those with which you are familiar as between the Dominion and the Provinces. My own feeling as a ratepayer and a taxpayer is that we do not pay anything like enough attention to checking the value which we obtain for our money. Our health insurance system certainly provides a notable example.

In the view of the Government the whole question boils down very largely to a question of amalgamating areas and rearranging boundaries to coincide with the movement of population. Accordingly they propose to establish a Local Government Boun-

(Concluded on page 90)



Correct surfacing promotes trustworthy absorption

BLACK LIGHT now helps Bauer & Black Suture technicians to analyze and select raw catgut for chromicizing. The color emitted by raw gut under ultraviolet light indicates its behavior in the chromicizing bath so that processing can be altered to compensate for variations in the raw material. This is the most recent achievement in our constant research toward even more reliable absorption in Curity Catgut Sutures.

MANY factors have their effect on catgut absorption.

Even the surfacing of the strand, as extraneous as it may seem, has a direct and important bearing on the rate of absorption.

A poorly integrated strand *(like A above)* allows enzymes to infiltrate between the plies . . . results in rapid loss of holding power.

Rough, "whiskery" surfaces *(like B)* usually cause further disruption of the suture during knot tying with consequent acceleration of the absorption process.

The Curity strand *(C above)* has a clean, smooth, firmly integrated surface which minimizes trauma and prevents premature enzymatic digestion . . . as well as a surface which holds knots firmly.

Uniformity and predictability of absorption have long been the subject of continuing reesarch at Bauer & Black. Each successive improvement in Curity Catgut Sutures has contributed its share to the increasing reliability of Curity absorption rates.

Curity stands for the finest in research and scientific attention to the manufacture of gauze, cotton, adhesive tape and combinations of these products. It is responsible for the unmatched quality of Curity Sutures.

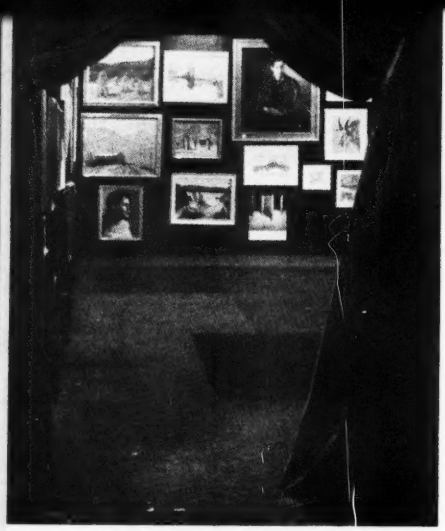
Products of

BAUER & BLACK

TORONTO, ONTARIO

RESEARCH TO IMPROVE TECHNIC...TO REDUCE COST

Curity
REG. IN CANADA



entrance to the Hall at one of the recent A.P.A.A. Exhibitions.

$34,000 in War Bond Prizes Offered to Physician-Artists

Topic: "Courage and Devotion Beyond the Call of Duty"

THE American Physicians Art Association, through the co-operation of Mead Johnson & Company, has announced a competition open to members of the medical profession with a series of prizes offered totalling $34,000. The subject to be portrayed is "Courage and Devotion Beyond the Call of Duty" on the part of members of the medical profession, either in military or in civilian practice.

The American Physicians Art Association, now in its 8th year, has a membership of 3,000 physicians, of whom almost 100, we are informed, are in Canada. Some very interesting exhibitions have been held, that in Chicago last June at the time of the A.M.A. drawing an entry list of 1,036 exhibits in different media. The man who has been responsible to a large extent for the successful development of this Association is one who is not himself a doctor. He is Mr. A. L. Rose, vice-president of Mead Johnson and Company, who has taken a deep personal interest in the exhibits and whose company has made it possible to offer a handsome series of cups and medals for prize-winners, as well as bearing the cost of express, shipments and hanging.

In arranging for the competition outlined below, Mr. Rose has pointed out that there are many instances, not only in military medicine but in civilian practice, where dramatic situations arise, situations where the doctor, faithful to the interests of his patient, takes personal chances, regardless of the possible result to himself. It is the opinion of Mr. Rose that the public in general has little realization of the number of times this arises in the day-to-day work of the doctor, be it on the battle field, in the home or in the laboratory.

Rules of Contest

1. *Subject:* "Courage and Devotion Beyond the Call of Duty"—on the part of members of the medical profession—in military or civilian practice. Any contestant may portray either the military or civilian aspect of the subject (or both, if shown in one piece).

2. *Media:* The physician-artist's choice of one of the following:
   1. Painting in oil or egg tempera.
   2. Water colour, transparent or opaque.
   3. Sculpture in any medium.
   4. Drawing in any medium.
   5. Prints, including etching, engraving, lithography, wood block and linoleum block (on paper or cloth).
   6. Photography, including bromoil, tinted and kodachrome, as well as photo-montage.

   Suggestions: Complete sketches* for mural decorations: in oil, egg tempera or water colour drawing; photo mural; bas relief sculpture; all are eligible.

3. *Eligibility:* Open to any physician member of the American Physicians Art Association,† including medical officers in the armed forces of the United States and Canada.

4. *Definition* of "medical officers in the armed forces of the United States and Canada": For the purpose of this prize contest, this term shall include all M.D.'s who at the expiration date of this contest, shall have served six months or more in the Army, Navy (including Marine Corps), Air Force or Merchant Marine of the United States or Canada during World War I or II. Physicians in the United States Public Health Service (or equivalent Canadian services) shall be considered as civilian physicians unless they have at least three months' foreign service during World War I or II.

5. *Prizes:* Forty-two prizes, divided amongst the two groups of physicians:

To Medical Officers:

1 $2,000 War Bond (E or F Series).
10 $1,000 War Bonds (E or F Series).
10 $500 War Bonds (E or F Series).

To Civilian Physicians:

1 $2,000 War Bond (E or F Series).

(Concluded on page 88)

*Specifications for these sketches: 1. Should be painted to the scale of one inch to one foot; (full-size detail may also be submitted, limited to 18 in. square). 2. Should be carefully finished in the medium of the original mural except in the case of fresco, where egg tempera may be substituted. 3. Should include simple architectural background, showing how the decorations fit into the setting.

†Any medical doctor residing in the Western Hemisphere, Hawaii or the Philippines may join the American Physicians Art Association upon application with one year's membership dues ($2.00). Membership dues to physicians in armed services are waived for duration only.

Here and There

By The EDITOR

First Aid by Helicopter

An illustration of how the helicopter can be a valuable ally in bringing aid to isolated victims was given last month by Mr. Frank H. Kelly, Jr., noted test pilot and official of the Bell Aircraft Corporation, speaking on "The Future of the Helicopter" to the Royal Canadian Institute at Toronto.

Flying at a high altitude from their Buffalo plant, one of their test pilots was forced to bail out from a new model plane under test. In clearing the plane he was struck by a section of the tail and was badly gashed about the head. Fearing that he was losing consciousness, he was forced to pull his ripcord sooner than he had intended, for the temperature at that altitude was 30 below zero. Unfortunately the sudden deceleration ripped the boots off his feet, and for fifteen minutes during that descent his feet were subjected to the intense cold, which was still only 10 above zero on ground level.

On landing in the deep snow, it took him half an hour to reach the nearest farmhouse, which fortunately had a telephone. Despite his suffering he was able to get in touch with the company, which immediately despatched its ambulance and a doctor to this farmhouse. Three miles from the farm the ambulance was halted by the deep snow.

Modern equipment came to the rescue. The ambulance was equipped with radio transmission and was able to signal its predicament back to the plant. Plant officials then decided to call out the helicopter. In a few minutes it was on its way, located the ambulance, settled gently down beside it, took on the doctor, rose again and in a few minutes came to earth in the farmyard. Meanwhile a snowplow was busily making a pathway for the ambulance, and three hours later the road was sufficiently clear that the ambulance could pick up the patient. It was the opinion of the plant doctor that if he had not been able to get to the patient as promptly as he did, the airman would probably have lost one or both of his feet.

* * *

"Aw, Let the Kid Have Her Fun!"

A professor in an eastern medical school is telling about a very logical but saddening answer which he noted in an examination paper turned in by a pupil nurse at one of the local hospitals. Asked what precautions she would take to protect herself

when nursing an open case of tuberculosis, she stated that she "would wear a mask" and then added (we are sure with a sigh), "and I would refrain from kissing the patient".

* * *

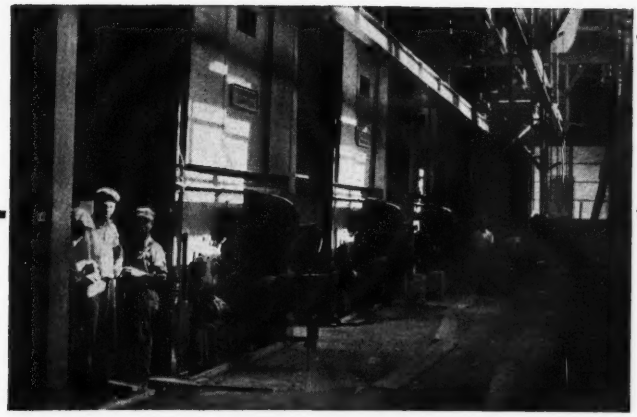
Yust Two Yolly Swedes!

Dr. H. V. Morgan of this Clinic (Calgary) tells a rather characteristic incident from his early practice in rural Saskatchewan. The Red Cross Society in those parts had a custom whereby it organized an annual "Tonsil Day" Clinic at one or other of the smaller communities. All school children or adults for fifty miles around who wished to avail themselves of having their tonsils removed, were gathered together in a large central hall or school and placed on stretchers or camp-cots and left to await their various turns. On this particular occasion, a spacious unused old pool hall provided the "torture-chamber". As the work progressed the place became one of blood, vomitus, corruption and uproar. The children were mercifully taken first and the adult procession followed in due and struggling course; in all probably a band of fifty. Last of all came two big husky uncouth Swedes who knew all about the effect of Copenhagen snuff and Scotch whisky. *Aether stat. and q.s.* was poured on each in turn until he subsided temporarily enough to snare out his tonsils; then the Swedes were deposited on closely adjoining cots to await their revival to Swedish good nature. The surgeons next retired to the home of the local physician for rest and afternoon tea. When they returned to the "Tonsil Mill" in about half an hour, the Swedes had arrived by an entirely new route, it is true, at that old and familiar stage of inebriation when it was time to roll and roar. One propped himself up and looked around, saw a patch of blood on his left arm and hand, and more on his pillow, and then spied his companion in a similar state of besmearment. Instinctively he knew his next move. With a roar and a snort and a volley of blankety-blank-blanks, he lunged on top of his collapsed associate and proceeded to finish the fight which he thought had wrecked him at its start. The surgeons, nurses, orderlies, the chaueur and some passers-by succeeded at length in restoring peace and order. The two heroes subsided and snored themselves back to good neighbourliness and friendship—and the Clinic went on its way rejoicing!

From the Historical Bulletin of the Calgary Associate Clinic.

* * *

By neglect of the study of the humanities, which has been far too general, the profession of medicine loses a very precious quality.—*William Osler.*



Actual installation of type E stokers in a large Ontario Hospital.

Steam Production Equipment for Hospitals that is saving them money

Today with fuel shortages and uncertain man-power supply, the economy and labor saving features of C-E power plant equipment appeals strongly to those concerned with hospital operating costs.

We shall be glad to submit actual figures showing how C-E equipment has paid for itself by the savings effected in hospital after hospital. In addition to this, these substantial savings have been accompanied by an improved and much more satisfactory steam production service.

Combustion Engineering Corporation is equipped to render a complete service in the design, manufacture and installation of all types of Fuel Burning and Steam Generation equipment. Our engineers will gladly discuss, without obligation, steam production problems with hospital managers and their architects.

C-E EQUIPMENT INCLUDES:

C.S.U. Stokers
Type E Stokers
Chain Grate Stokers
Travelling Grate Stokers
Fuel Economizers
Water Cooled Furnaces
Air Preheaters
Powdered Fuel Equipment
Oil Burning Equipment

These Hospitals use C. E. EQUIPMENT

B.C. Provincial Mental Hospital, Essondale
Children's Memorial Hospital, Montreal
Christie Street Hospital
Freeport Sanatorium
Hamilton General Hospital
Hotel Dieu de St. Valier, Chicoutimi
Jubilee Hospital
Metropolitan Hospital
Montreal General Hospital
Mount Hamilton Hospital
Muskoka Hospital for Consumptives
New Westminster Hospital
Ontario Hospital, St. Thomas
Queen Alexandra Sanatorium
St. Lawrence Sanatorium
St. Michael's Hospital
Toronto General Hospital
Tranquille Sanatorium
Vancouver General Hospital
Waterloo County House of Refuge
Wellesley Hospital
Westminster Hospital
Weston Sanatorium
Winnipeg General Hospital
Women's College Hospital
Woodstock General Hospital

Combustion Engineering Corporation *Limited*

MONTREAL TORONTO WINNIPEG VANCOUVER

Dish Washing and Sterilizing

IN a study of hand dish washing practice in several restaurants Mallman has shown that after an educational programme bacterial counts on dishes could be reduced from several thousand to less than 100, and that an average count of 67 was maintained over a period of two years as compared to an average of 36 for another series of tests on dishes washed by machine.

A good detergent should have the following properties:

1. Wetting; the ability to wet readily the utensil being cleaned.

2. Emulsification; the ability to emulsify the fats from the food soil on the utensils.

3. Dissolving; the ability to dissolve food materials, principally proteins.

4. Deflocculation; the ability to break up food particles.

5. Dispersion; detergent should function in hard or soft water, with minimal formation of film or deposits on utensils.

6. Rinsing; the property of being easily rinsed off the utensil by clean water.

No single chemical substance possesses all these properties to the desired degree. Many detergents used for dish washing are mixtures.

The selection of detergents on a scientific basis is quite complex, as no satisfactory method of evaluating them in simple terms has been devised. The ingredients can be evaluated in terms of six essential properties but the difficulty arises in trying to combine these individual properties into an overall efficiency rating, although efforts to devise such a test are now under way in New York.

The following factors influence the selection and efficiency of a detergent: hardness of water, equipment to be used, temperature, time of contact, and concentration. A concentration of about 0.3% is in general the most satisfactory but this varies with different detergents. None of the methods of testing the concentration is entirely satisfactory and reliance must still be placed on approximate methods.

Condensed from an article in "Public Health Reports" by Hospital Abstract Service.

Hand Dish Washing Methods

Facilities required include a 2 or 3-compartment sink of sufficient size and adequate drain boards, provision for convenient scraping of dishes and disposal of scrapings, a pre-rinsing arrangement, baskets for utensils, adequate hot water facilities, a suitable detergent, an intelligent dishwasher and capable supervision.

Dishes should be scraped well, pre-rinsed and sorted. Wash water should contain a sufficient amount of a suitable detergent and be as hot as the hands can stand—110° F. to 120° F. During washing water temperature drops, water becomes laden with food particles, grease, etc., and detergent becomes weakened. Washer must add detergent, keep water hot, and change water before it comes too dirty.

Washed utensils should be placed in baskets in the second compartment of the sink. Dishes should then be given bactericidal treatment by immersion in hot water or a chlorine solution. Glasses and cups should be placed on their sides to avoid entrapping bubbles. The baskets containing the dishes are immersed in the second compartment in water at 170° F. or more for at least two minutes. Water must be maintained at 170° F. or more, usually by use of some type of coil or heating element in the compartment. In this arrangement both the rinsing and the bactericidal treatment take place in the second compartment. A three compartment sink is preferable, using the second for a warm rinse and the third for the hot bactericidal rinse. If chlorine is used for bactericidal treatment the third compartment is mandatory unless there is some other rinsing or spraying device to substitute for the second compartment. In case of a chlorine treatment the rinsing must be especially good and the bath must be maintained at 50 p.p.m. available chlorine or more.

After bactericidal treatment dishes must be allowed to drain and dry. If scalding method is used they will air dry quickly. If chlorine method is used the dishes may be rinsed again to remove chlorine odour and may have to be dried with a towel, especially if water is very hard. In any case towels must be clean. There is at least one promising substitute for chlorine as a bactericidal agent—alkyl - dimethyl - benzyl ammonium chloride, which is said to maintain its action better, to rinse more freely and to be free from odour.

Machine Dish Washing

One-tank machines are subject to the general objection that the hot

(Continued on page 68)

Regional Conference Planned for Western Ontario

We are informed by Mr. Horace Atkin, Superintendent of the Metropolitan General Hospital, Windsor, Ontario, that a regional conference of hospital executives is to be held in Chatham on Wednesday, March 28th, through the courtesy of Miss Pricilla Campbell, Superintendent of the Chatham General Hospital. The conference will be held at the William Pitt Hotel commencing at 1.00 p.m.

Invitations have gone to the various public hospitals in this area requesting them to send a number of representatives to the conference. All public hospitals in Western Ontario have been invited.

The preliminary agenda covers administration, nursing and purchasing, and includes such items as rates charged for various services, hospital visitors, office routine and the use of machine equipment for accounting, means of securing student nurses, conditions affecting graduate nursing and a number of problems relating to voluntary helpers. Under the heading of purchasing there will be discussions on shortages, systems of purchasing and group purchasing.

Information relating to this conference can be obtained from Mr. Horace Atkin.

"WE ARE BEGINNING TO WONDER HOW WE MANAGED SO LONG WITHOUT ONE"

says

Regina General Hospital

of the

Class 2000

NATIONAL SYSTEM

REGINA GENERAL HOSPITAL
REGINA, SASKATCHEWAN

February 3, 1945.

FILE NO.
SUBJECT NO.

The National Cash Register Co. of Canada Ltd.,
Lansdowne and Dundas Street,
Toronto, Ontario.

Dear Sirs:

The installation on December 12th, 1944 of one of your Posting Machines has proved of inestimable value to this Institution. It is too early to estimate the exact saving in time and expense, but it is quite evident now, that this will be very considerable. The ease of operation and the speed with which four members of the Staff have achieved skill in manipulation is to be highly commended. A simpler method of bookkeeping has not come to our attention and the ease with which we can obtain an exact balance at the end of each day's business is well worth a change from old-fashioned methods. Much to our surprise, the human element has proven far more accurate with the machine than it did with hand recording and the loss from belated charges has almost disappeared.

From a patient's angle much of the annoyance of having to wait until accounts were made up, has now been eliminated, a few seconds being sufficient to complete any account no matter how long the party has been hospitalized.

The best recommendation, we can give your machine, is the fact that we are now beginning to wonder how we managed so long without one.

Yours very truly,

G. E. Patterson

SUPERINTENDENT (Acting)

GEP/WB

● At the Regina General Hospital . . . and in many other institutions throughout the Dominion . . . the National System is daily demonstrating its value.

Read what the Regina General Hospital has to say about the Class 2000 National System . . . how much it has simplified every bookkeeping duty . . . how tremendously it has improved accounting methods over the old-fashioned system of hand-recording . . . how great an advance in accuracy it has achieved . . . how easy it has made it for superintendents and managers to enjoy at all times a complete and detailed control over every accounting transaction. Wherever it is installed, the same verdict is pronounced on the National System:— **No other system has yet equalled its speed and flexibility . . . its saving of time and expense . . . its quick adaptability to any and every bookkeeping and accounting problem.**

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HEAD OFFICE: TORONTO, CANADA **SALES OFFICES IN PRINCIPAL CITIES**

Dishwashing and Sterilizing

(Continued from page 66)

water runs back into the wash tank and weakens the detergent by dilution. Also, it may raise the temperature of the wash tank so high as to "cook" the food particles on the utensils. Also, they are slower in action because machine must be stopped after each charge, and wasteful of hot water since excess due to addition of rinse water drains to the sewer. One design however separates the rinse spray from the washer spray and thus avoids overheating and dilution.

Two-tank machines have a recirculated rinse before the final fresh water rinse and save hot water because last hot rinse can be considerably shorter.

There are a number of other designs including one having a prerinse device to remove considerable soil before dishes reach the wash tank. Some have 2 wash tanks and a recirculated rinse.

General considerations are that sprays or jets must be so designed as to reach all surfaces of the utensils when properly racked, and should be easily accessible and removable for cleaning. Temperature of water in both wash and rinse lines should be thermostatically controlled and both lines should have easily visible thermometers. Properly operating automatic detergent dispensers are also recommended.

Additional factors influencing efficiency of machines:

1. *Length of washing period.* Acceptable results are obtained in at least 40 seconds to one minute.

2. *Temperature and duration of rinse.* If preceded by an adequate wash 15 to 30 seconds at 170° is sufficient.

3. *Rush hour.* Operators are tempted to cut short the operations at the rush hour. Dish supply should be sufficient to carry over the peak of the rush hour, thus obviating the need for any such curtailment of proper dish washing procedure.

4. *Rate of dilution of wash water.* Some dilution is necessary to keep the wash fairly clean, to flush floating material into the overflow, and to restrict rise in bacterial count which might otherwise actually become greater than that on the dishes being washed. But overdilution is equally objectionable.

5. *Adding the detergent.* Continuous addition at a rate controlled by the strength of the detergent in the wash water is the ideal. Simplest method is to fully charge when tank is first filled and then add charges at regular intervals during operation. For instance, one detergent manufacturer recommends for water of 5 grains hardness or less, 1 oz. for each 5 gallons of tank capacity; for single tank machines 1/3 the initial charge for each 20 minutes of operation and for double tank machine 1/3 the initial charge for each hour of operation. There are several types of automatic detergent dispensers.

6. *Method of racking utensils.* Do not overcrowd. Dishes, saucers, etc., should not be nested but should be placed on edge and leaned back slightly so as to expose the food side of the dish to the spray. Utensils of different sizes should not be mixed. Cups and glasses should be inverted so they will drain. Cups should never be placed on top of trays of other dishes.

7. *Clogging of sprays and nozzles.* Unless sprays and nozzles are cleaned frequently accumulated food particles will clog them. Even the rinse sprays may become clogged. All should be cleaned frequently and regularly and even daily cleaning may be necessary. Strainers and trays above wash tank should be kept clean and at the end of the day the machine should be emptied and the interior scrubbed, hosed, or flushed with clean hot water, and immediately drained off to prevent grease from congealing as the water cools.

8. *Adequacy of hot water supply.*

(Continued on page 70)

With the Auxiliaries

Ontario

The auxiliary of the *Victoria Hospital, London,* held a membership tea recently when new members were received. One much appreciated service done by this auxiliary is the library service to the patients. The Shoppe and tea room, another of the aid's ventures, serves several thousand persons yearly.

At the Annual Meeting of the *Goderich Hospital Aid,* Mrs. D. E. Campbell was elected president. Two members of the aid were appointed to the Hospital Board. This group works in close co-operation with the Goderich Township Rural Aid.

Wingham Hospital aid was publicly thanked in the annual report of the superintendent for the faithful work done all year in the hospital's behalf.

Listowel Hospital auxiliary recently elected Mrs. R. H. Hanna as president. Among gifts made to the hospital during the year was an oxygen tent.

January Nite, sponsored by the auxiliary of the *Women's College Hospital, Toronto,* realized around three thousand dollars for the work of the aid. Three hundred men of the forces were guests on this occasion.

A junior hospital aid was recently formed to work for *Welland County General Hospital.*

Mrs. Magee is the president of the *Ingersoll Hospital* aid, which is doing fine work for the institution.

Reports given at the annual meeting of the *Dunnville Hospital* aid showed a satisfactory record of accomplishment for the hospital.

Peterborough Hospital aid has added ten new life members to the already large number on the roll.

Owen Sound Hospital auxiliary held its annual meeting recently, when Mrs. A. B. Rutherford was elected president.

Clinton Hospital recently received a fine coloured steel engraving of Florence Nightingale, given in memory of Nursing Sister Ferguson, who gave outstanding service in the first Great War, by Mrs. O. W. Rhynas.

Members of the Aids Association will regret to learn of the illness of Miss Theo. MacKelcan, which will necessitate her giving up her position as recording-secretary of the Association.

Five hundred dollars is now available in the provincial fund to send another quota of cigarettes to men of the forces.

Shortage Acute in Windsor

THE shortage of beds in Windsor, Ontario, is causing grave concern in that busy city. The fact that similar shortages exist in most other centres in Canada may give some degree of comfort and moral support, but does little to help the situation in Windsor.

As the local press laments, "Nowadays when you get an ache you have to compete with people with freshly-broken backs, acute kidney disorders, aggravated gall-stones, 10-month pregnancies, gun-shot victims and others with top priority ratings".

"Three-quarters of the people who came to my office today", moaned one Windsor doctor, "are persons whose cases I diagnosed weeks ago as serious. They weren't in here for a re-check. They came in demanding beds."

Another doctor claimed to be spending half his waking hours telephoning city hospitals on a 15-minute call system, in the hope that he would be able to squeeze someone in somewhere.

Despite recent additions to the Hotel Dieu Hospital and Grace Hospital, the available accommodation is far short of meeting the demand. One ambulance driver stated: "I thought the other day I would have to keep a patient riding around with me all day. It's almost so bad now that you have to check to see if you will be able to get rid of a person before you know it is safe to go and pick him up."

Mr. Horace Atkin, superintendent of the Metropolitan Hospital, stated that there would have to be a whole new hospital added to the present accommodation before the situation would be relieved. There was much need, he said, for more bed space at the city's Metropolitan Hospital.

Apparently they must move their patients around a good deal in Windsor. One woman was heard to complain the other day: "Hospital, nothing! This is an assembly line. I haven't stopped moving since I came in!"

We are relieved to be informed by the press, however, that there is no truth in the report that a man with two broken legs, goitre, diabetes and scarlet fever was seen shortly after midnight recently pushing a hospital bed up the front steps of the Metropolitan Hospital.

Canadian Hospital Council to Meet in Hamilton

Plans are now under way for the meeting of the Canadian Hospital Council at the Royal Connaught Hotel in Hamilton from Wednesday, September 19th to Friday, September 21st. As the two-day session in previous years has proved to be inadequate for the discussions desired, the programme is being extended this year to a third day. The associations have been asked to select their official delegates and alternates, if this has not already been done. However, as in previous years, a general invitation is extended to all people interested in hospital work to attend these helpful sessions.

As the meetings of the Council are held on alternative years only, and as much has transpired in the hospital field since the last meeting in 1943, it is anticipated that a strong and representative group from the hospital associations across Canada will be in attendance at this meeting. Reservations should be made early.

New Hospital Construction Planned in Maritimes

Steps are being taken to relieve the hospital situation in Nova Scotia and Prince Edward Island, as soon as material and manpower become available. Pictou County towns have committed themselves to replacing the present Aberdeen Hospital in New Glasgow with a new million dollar building. At Halifax, work is progressing on the construction of a 15-storey multi-million dollar provincial government hospital. The new building is being built on the Victoria General Hospital grounds. A new wing will be added to the All Saints Hospital at Springhill. At Charlottetown an addition to the town hospital will be made as soon as material is available.

Soldiers' Wing at University Hospital, Edmonton, Now in Use

The new D.V.A. building at the University of Alberta Hospital, Edmonton, known as the Colonel Mewburn Pavilion was officially opened on February 22nd. The Hon. James A. MacKinnon, Minister of Trade and Commerce, officiated, assisted by many government officials and civic and provincial dignitaries. This is a fine new three-storey brick and steel building, entirely fire-proof and with a minimum capacity of 250 beds. The Pavilion is under the direct charge of Dr. D. G. MacQueen, sub-district administrator and assistant chief medical officer for the Department of Veterans Affairs. Dr. A. C. McGugan is general superintendent of the University Hospital with which the Colonel Mewburn Pavilion is connected.

Blue Cross Director Honoured

Miss Ruth C. Wilson, Executive Director of the Maritime Blue Cross Plan for Hospital Care has been appointed a member of the National Blue Cross Enrolment Committee, U.S.A. and Canada.

Dishwashing and Sterilizing

(Concluded from page 68)

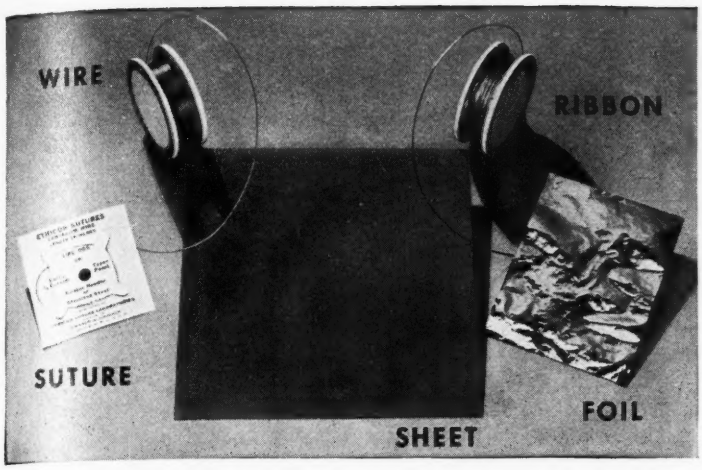
There must be sufficient supply of water at 170° F. for the final rinse even if booster heaters are required to heat it. And this temperature must be maintained at the machine, no matter how far from the water heater.

9. *Defects of some washing machines.* Desirable changes in design include: make it easier to clean tanks, pumps and piping; improve valve design and location; protect better against back siphonage; prevent back flow to waste lines into wash or rinse tanks.

10. *Operation supervision and tests.* All operators should be taught proper methods and the importance of adhering to them.

Vigilant inspection is necessary to determine if utensils are clean. Charcoal dust dusted on to clean utensils will adhere to unclean spots.

For bacteriological examination it is considered that standard swab test yielding more than 100 colonies indicate bad dish washing.



What is TANTALUM?

Tantalum, the versatile new metal for surgical procedures, has many useful applications. As, in the scientific journals, surgeons report beneficial results from its use, hospitals will receive more and more requests to supply it. Present experimental and clinical evidence indicates that tantalum is superior to silver, steel and alloys as a metallic substance for non-absorbable sutures and bone plates.

SUTURES . . . used and tied in the same manner as other non-absorbable sutures. 6-0, 5-0, 4-0, swaged to eyeless Atraloc needles. *WIRE* . . . for suturing. Supplied on spools. Several sizes. RIBBON . . . for hemostasis clips; also orthopedic, facio-maxillary surgery. *FOIL* . . . for sleeve or cuff to protect nerves, prevent adhesions. *SHEET* . . . for cranioplasty; reconstructive or plastic repair work. Descriptive literature on request.

ETHICON *Sutures*

Complement the Surgeon's Skill

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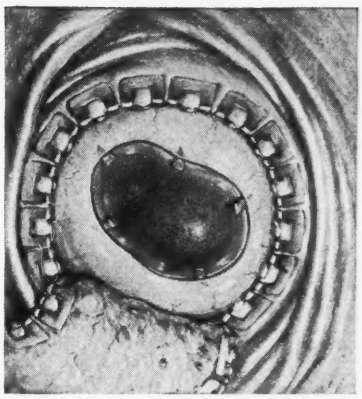


SKULL REPAIR

Tantalum plate inlaid on bone shelf surrounding the defect. Plate is flush with skull surface and secured by triangular tantalum points.

HERNIOPLASTY

Modified Bassini operation. Tantalum sutures approximating internal oblique aponeurosis to Poupart's ligament. Of value in recurrent hernia or in infected areas.

NERVE REPAIR

(*Inset*) Fine gauge tantalum sutures approximate epineurium of severed median nerve... Tantalum foil wrapped loosely about repaired section and secured by loose ties.

Syphilis and Pregnancy

Because:

(1) During pregnancy active lesions of syphilis are rarely seen, and;

(2) A history of a previously known primary lesion is rarely obtained;

Therefore:

Diagnosis can be made *only* by repeated blood tests.

"Blood Tests for Every Expectant Mother Before the Fifth Month."

* * *

Pelouze " . . . . in line with the March of Progress"

The time is here again when we must hasten to erase past faults, and get ourselves in line with the march of progress. None of us is too good to treat gonorrhea and none is justified in treating it by the old haphazard ways still so commonly held. The same society that looked down upon gonorrhea as a just reward for what it called "sin" is being rapidly awakened to the enormity of this problem, and the time is here when every physician should know more about the disease itself and what it means to society than about its purely therapeutic aspects.

* * *

"20 Arsenical"

Never let a patient lapse from treatment for early syphilis till he has had a minimum of 20 intravenous injections of arsenical. More than "20 arsenical" is advisable as a rule, less than "20 arsenical" never!

Coming Conventions

March 26-27—Alberta Association of Registered Nurses, Calgary.
April 6-7—Rgistered Nurses Association of British Columbia, Vancouver.
April 16-17—Manitoba Association of Registered Nurses, Winnipeg.
June 11-15—Canadian Medical Association, Mount Royal Hotel, Montreal.
June 19-22—Maritime Hospital Association, Charlottetown, P.E.I.
September 19-21—Canadian Hospital Council, Royal Connaught Hotel, Hamilton.
October—Ontario Hospital Association, Royal York, Toronto.
October—Ontario Conference, Catholic Hospital Association, Toronto.

To Enlarge Royal Alexandra Hospital at Edmonton

The Edmonton city council has approved three items of necessary construction at the civically-owned Royal Alexandra Hospital. These three improvements, totalling $250,000 in cost, are to be undertaken as soon as possible.

Projects approved are: construction of a new power plant sufficient to meet the hospital's future needs, $100,000; construction of a 50-bed chronic treatment hospital for aged and crippled patients, $100,000; and a new rotunda at the main entrance of the hospital, $50,000.

Laundry Machinery

(Continued from page 39)

from the spiral rolls at the rear of the machine. Instead, control of the aprons should be handled from the control rolls only. This is important, because guiding aprons from a spiral roll only has a tendency to stretch them, and cause wrinkles to develop in the centre of the apron or to the side. Proper use of the control rolls will avoid this.

When the time comes for applying new padding or top cover to the ironer, this should also be supervised by a responsible person to see that it is done correctly. In order to get good production from a flatwork ironer, the padding must be applied to the machine correctly. The correct procedure is to start at the very front of the machine to be sure that the ribbon-feed drive roll is covered with No. 12 duck which is securely glued to the roll. This will assure correct speed of the ribbon-feed, so that there will be no slipping of the ribbon-feed in sending work into the roll.

When the rolls are padded, they should be graduated slightly so that there is a nice even pull of work through each succeeding roll. The padding should also be applied to take full advantage of the entire length of the padded rolls. When production has been finished for the day the ironer should be run for at least 15 or 20 minutes on light pressure at slow speed. This will help remove the moisture which has built up in the roll over the entire day's operation. Then the night cloth or apron should be run through the machine between the padded rolls and chests, also between the inside apron and the bottoms of the chests. This will protect covers, padding and inside apron from direct heat while the machine is idle. This type of operation, combined with the co-operation of the washroom in correctly conditioning the work for the flatwork ironer will result in extended efficient life of padding and aprons and will assure maximum machine production.

Correct Roll Diameter

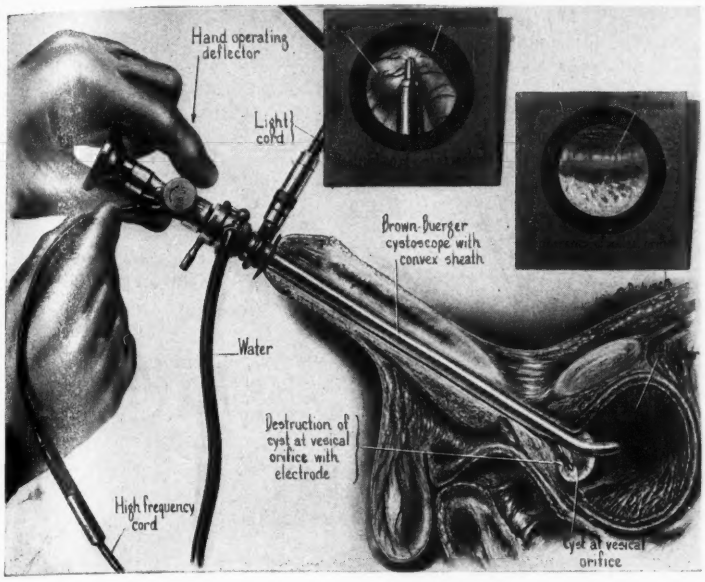
The padded rolls of flatwork ironers should be kept within certain limitations as to diameter. On chest type machines, the padded rolls should never be below 12⅛" and never above 12⅜" in diameter. The chests are machined for a 12 3/16" contour. It is evident, therefore, that rolls larger than 12⅜" will not fit into the chests correctly. When rolls are smaller than 12⅛" valuable ironing surface will be lost. Roll diameter can be kept within correct limitations by the use of padding size and lengths specified by the machine manufacturer, and by changing and applying all the padding as a complete unit when the rolls get below efficient minimum size.

Correct adjustment of the roll-pressure screws and pressure device is important in maintaining efficient roll sizes. This adjustment can best be made by a qualified engineer from the machinery manufacturer and should not be tampered with once it has been correctly made.

Keep Clean

Be sure also that a wax cloth is run through the ironer at least three or four times during the day,

BLADDER CYST DESTRUCTION



WITH THE

A. C. M. I.

Brown-Buerger

CONVERTIBLE

CYSTOSCOPE

The illustrations by William P. Didusch show the successive steps in the destruction of bladder cysts at the vesical orifice with an A.C.M.I. conical tipped electrode passed through the sheath of the Brown-Buerger Convertible Cystoscope using a high frequency current.

The sheaths are gently beaked for ease of introduction. For fulguration and other procedures on the posterior areas, the convex-type shown is particularly applicable, due to the close approach it permits to the bladder wall. The installation of a removable fin makes these "convertible instruments" equally efficient for ureteral catheterization.

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URETHROSCOPES, CATHETERS

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and a kerosene cloth should be passed through it at least two or three times during the week. It is necessary for the wax and kerosene cloths to be used so that the top and bottom surfaces of the chests will be treated alike. Some plants wax only the top sides of the chest, but this means that an accumulation of residue builds up on the bottom of the chests. This will cause rolling or snubbing of work, which retards production.

Plants which use sizing must keep the No. 1 chest at the feed board clean at all times. If not, there will be an excess of rolling at this point from the build-up of sizing and verdigris. The lips of all chests should be cleaned periodically to remove such accumulation.

We have had customers report that it was impossible to iron on the entire width of their flatwork ironer due to an accumulation of oil on the ends of the padded rolls. This will not happen if the shanks of the rolls are kept free of oil, by making sure that the oil cups are feeding only the amount of oil required to the bearing boxes. The reason the shanks accumulate this excess oil is over-oiling or because the nipple which holds the cup is cracked.

Cleaning the shanks of the padded rolls is very important maintenance duty because if you are unable to use the entire width of the machine production will suffer. Another result will be that the ends of the rolls will remain large in diameter while the centres will pack down to a smaller diameter. Cone-shaped rolls will result in rough drying and uneven pasage of work, because ironing pressure will be confined to the outside ends where the roll is large, while the centres will do little or no work. It is good practice, therefore, to alternate the work going through the ironer by feeding one lot of large work completely to the right side and the next completely to the left. In that way the rolls will be kept evenly packed at all times, cover and padding distortion will be avoided, ironing quality will be better and production improved.

We have attempted to analyze some of the undesirable operational habits that have developed in laundry practice on the larger pieces of equipment. Similar conditions might exist on any other equipment in the laundry. There are certain sensible, efficient methods of operating any laundry machine, but it is only with the full knowledge of and complete adherence to these methods that real production can be obtained.

Administration Course Now Under Way in Edmonton

The two months' course for the administrators of small hospitals is now well under way in Edmonton. This course has been sponsored by the School of Nursing, Faculty of Medicine, University of Alberta, at the request and under the auspices of the Alberta Association of Registered Nurses. The course has been made possible by the Dominion Government grant awarded to the A.A.R.N. This course has been designed especially to help the small hospital administrator and covers a wide range of topics of concern to the nurse administrator.

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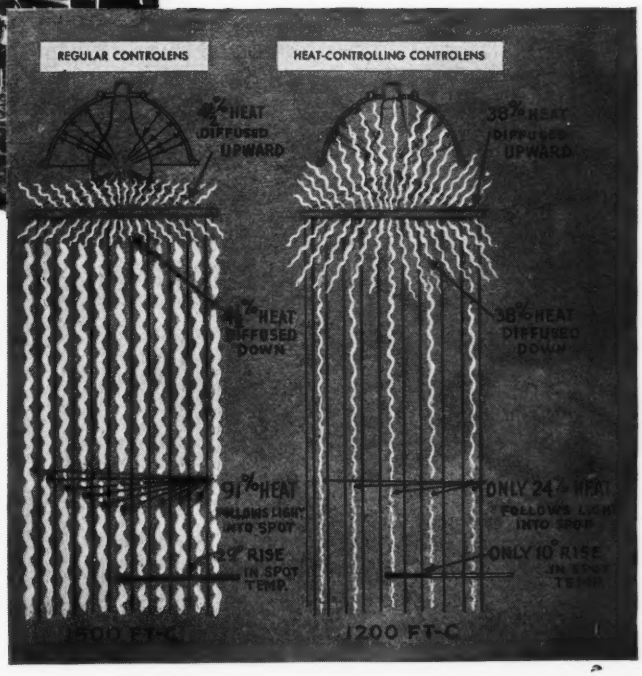

SINCE 1898 — systems of illuminating surgeries, developed by Holophane engineers, have been recognized by authorities as the most effective, permanent lighting for this specialized purpose . . . Today, in the new heat-controlling Controlens, Holophane makes another contribution to hospital efficiency.

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Standard Nomenclature

(Continued from page 50)

of medical knowledge and are obstructing their own development. It is possible also, that a record librarian may spend much valuable time on other systems. For instance, using an antiquated system, she may write or type all of the details necessary. *Standard Nomenclature* employs code instead of lengthy and numerous words.

The American College of Surgeons does not demand the use of *Standard Nomenclature* but has implied its favour in the 1941 edition of "Manual for Hospital Standardization", where it is stated that much attention is being directed to *Standard* because of its uniformity. In case of a hospital striving for standardization, the use of this nomenclature would enhance the record department considerably. In the same manner, a record librarian having a knowledge of *Standard Nomenclature* is one whose services are more valuable.

Standard Nomenclature has been favoured by numerous scientific organizations. The fact that it has been introduced in all leading hospitals in the United States and Canada, speaks forcibly in its favour. Both the American and Canadian Associations of Medical Record Librarians stress the study of this nomenclature. Detailed instruction in the use of it is an important part of the curriculum in schools for training of medical record librarians. Special courses have been arranged for instruction in the fundamentals of the system and its discussion is an interesting feature of annual conventions. In 1941, the Canadian Hospital Council appointed a special committee on Nomenclature of Disease. Recommendations made after careful consideration were in favour of official recognition of *Standard Nomenclature of Disease.*

The United States Public Health Service has indicated that they are anxious to obtain more definite information regarding the nation's illnesses. Mortality data have been available in the United States and Canada through the required registration of deaths, but general morbidity data are most difficult to obtain. Industry has been giving much attention to sickness and accidents. By the use of a unified nomenclature their various physicians and statisticians could compile valuable information. Many health insurance plans have been set up; all require diagnoses of cases. Uniformity would make their statistical reports an easy task. The Department of Health demands a diagnosis for all hospital admissions, but any attempt to compile statistics would be in vain due to inaccurate and incomplete diagnoses received.

Although universities do not give instruction to medical students in the use of *Standard Nomenclature,* this step has been considered. However, as soon as a student arrives at a modern hospital, he becomes acquainted with the system. The record librarian should invite new students to discuss its features. Because the intern already has a knowledge of diseases and causes, the only instruction necessary is an explanation of the index. The arrangement of terms is strictly alphabetical, entries for the most part being the anatomical site, or part affected. With the page refer-

ence is the etiological code number which assists in spotting the diagnosis on the page. The record librarian should also point out the distinction regarding the disease and its manifestations. Again, these are points the student has learned previously. By use of the *Nomenclature* the intern benefits directly, since he will acquire the habit of writing accurate and complete diagnoses.

A factor in the general acceptance of the *Nomenclature* relates to those former interns who had become accustomed to its use. They will have started practice in various hospitals. The record librarian planning to introduce *Standard Nomenclature* in her hospital may find, on questioning the younger members of the medical staff, that a substantial percentage is familiar with the *Nomenclature*. To the other members of the staff, she should point out that the system does not make great demands on the physician. The record librarian has been trained to utilize the system, the physician's part being merely to make accurate and complete diagnoses according to the *Nomenclature*. In view of advantages for research teaching and statistics, the medical staff should not hesitate to approve of *Standard Nomenclature*.

We must not omit the financial element. The main expense may be obtaining books for various departments. Filing cabinets are small and thus do not entail great expenditure nor take up much space in the record department.

In conclusion, we must agree that the *Standard Nomenclature of Disease* is necessary to every modern hospital, that it is not as complicated as we may think, and that it is authentically and permanently organized as the result of much careful study and planning. It is the answer to the great need for unified scientific disease indexing. Leading authorities have accepted it—why not you?

"The Canadian Hospital"

(Continued from page 48)

supported our first issue and who have been consistent advertisers throughout the years. These firms are: Corbett-Cowley Limited, Davis and Geck, Inc., T. Eaton Company Limited, Metal Craft Limited and G. H. Wood and Company Limited. Without their encouragement Mr. Edwards doubts if he would have had the courage to launch *The Canadian Hospital*.

Whatever the new peace era of hospitalization in Canada may bring, the various interests with whom we are associated may be assured that every effort will be made to maintain *The Canadian Hospital* as a medium of leadership in all that pertains to the welfare of our hospitals and the services they render to the people of Canada. —*Eleanor Wrenshall.*

Fredericton Chairman Resigns

Mr. Luke S. Morrison has resigned as president of the trustee board of the Victoria Public Hospital at Fredericton, N.B. Mr. Morrison was instrumental in building the new addition to the hospital and his services will be greatly missed. He has been succeeded by Mr. John A. Reid, well-known president of the Hartt Boot and Shoe Co. Limited, and a former president of the New Brunswick Hospital Association.

Britain Guards Health

(Concluded from page 55)

There will be no compulsion for doctors to join the *National Health Service* and doctors who take on a public practice will be free to have a private practice as well. The general practitioners will be centrally organized. A *Central Medical Board,* appointed by the Ministry of Health, will administer the service and act as "employer" of the doctors. Doctors in the Health Centres will enter into a three-sided contract with the Central Medical Board and the local authority.

It is proposed that young doctors new to the service will begin their work as apprentices to experienced general practitioners. Doctors in the Health Centres will be salaried workers while those in separate practices will be on a capitation system similar to that now used under the National Health Insurance scheme. Should the Central Medical Board consider any area to be "over-doctored" permission may be refused for doctors wishing to set up a new or to take over an existing public practice. A scheme of compensation is being worked out for present practices which lose their value. A superannuation system will be worked out for doctors in Health Centres.

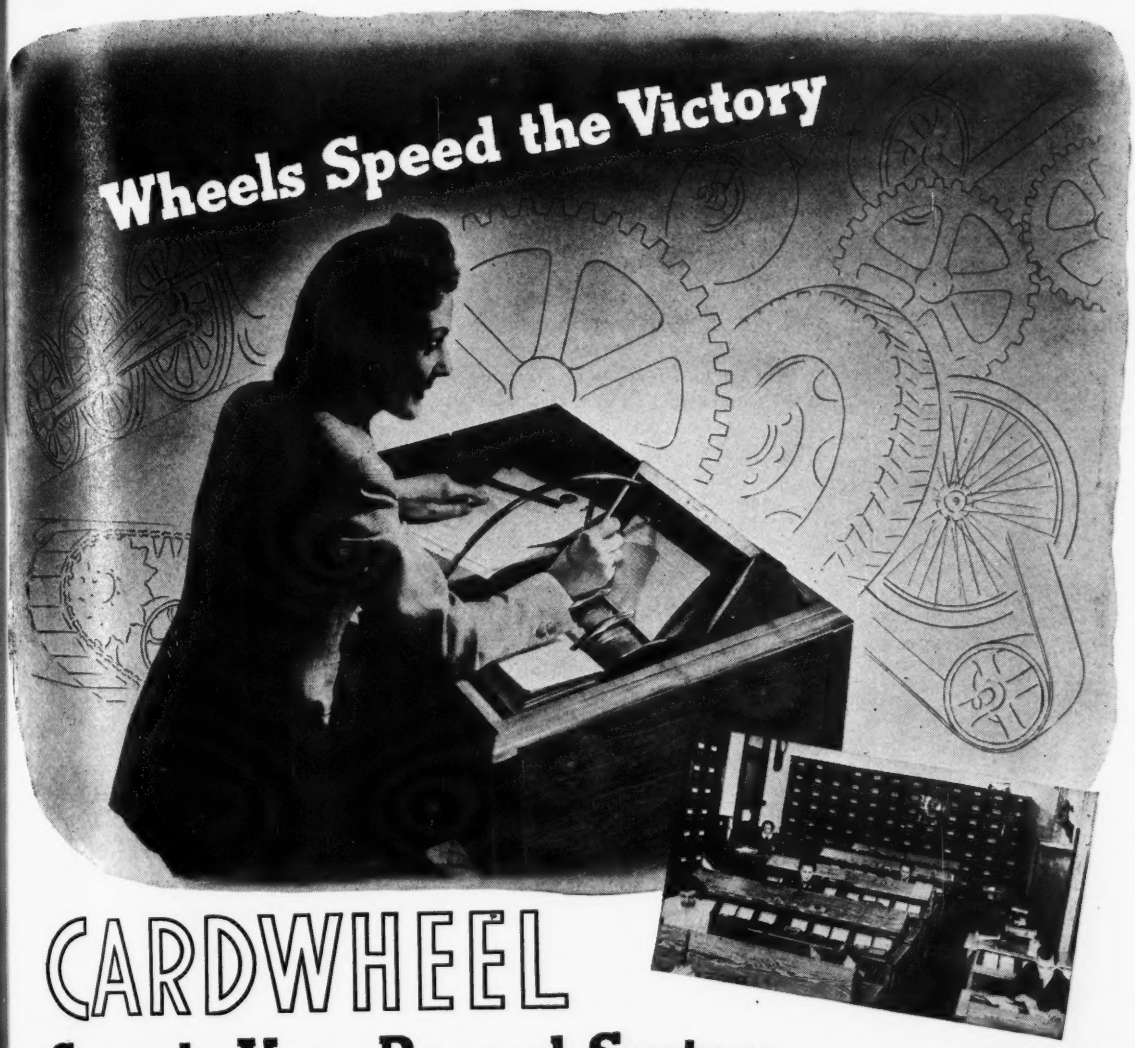
The White Paper states that the Government wishes to ensure for every man, woman and child *"that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them or any other factor irrelevant to the real need—the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens".*

One Boon of War

Mark Twain once observed that there never was a "good" war. However, out of this war there have come many great advances that will succour humanity in the years ahead, such as blood plasma, the sulfa drugs, and penicillin. However, there is another great advance in our wartime medicine which is not so obvious but every bit as real. I refer to the great work that the military hospitals are now performing in the management of the convalescent. In the old days convalescence in the army used to mean "sitting around". This routine invariably caused the individual to wander aimlessly about, bored stiff. Today the lot of the convalescent is totally different. He does exercises, studies langauges, is taught remunerative occupations and is stimulated in every possible way. His morale is higher than that of his counterpart in the last war. He is handled according to his background to become a worthy citizen. Convalescence will no longer be a step-child in the field of medicine.

In Britain and the British Commonwealth we propose to learn the lessons of this unfortunate war and apply them. We will highly resolve to treat, not only the disease but also the man. We will not leave him until he has been rehabilitated in his old, or in a completely satisfactory new way of life.

The convalescent will not be drilled and spied upon in a mawkish busybody atmosphere. He will be guided in a spirit of friendship and sympathy. The hospital and ancillary bodies will not say "we cured 90 per cent" but rather "we restored 90 per cent to responsible citizenship".



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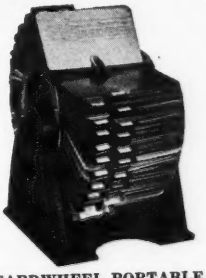
The switch-over from your present system to CARDWHEEL takes but a few hours.

Consult our Systems Department on your posting and reference problems.



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Keep Spick and Span

(Concluded from page 44)

through long wear or disuse. Once a base is built upon the rubber surface, it is only necessary to remove the surface layer to remove the dirt. At intervals of perhaps four months, the floor will become discoloured by repeated application of wax, and it may be necessary to use a cleaning solution to remove the whole wax surface. Here again two thin coats of wax well polished give much better results than one heavy coat.

Linoleum should be washed with warm water and a mild soap, using due care not to flood the floor with water, as it seeps through the joins and rots the linoleum backing. When clean and dry, linoleum can be waxed with one or two thin coats of water wax and polished. Often just wiping up with water and a cloth will remove soil from either rubber tile or linoleum, and a cleaner should only be used when absolutely necessary. Old linoleum floors can be restored by cleaning thoroughly, treating with one or two coats of sealer, and then one or two thin coats of wax.

Terrazzo floors should be scrubbed with a good cleaner and dried well before applying a finish. Terrazzo dries slowly and two or three hours is not too long to wait before applying a finish. Some apply one or two thin coats of wax; and others advocate a special terrazzo finish—both followed by polishing to bring up a lustre.

Tile floors need a good scrubbing with a good soap solution at least once a day, and should be treated regularly with a disinfecting solution, especially in bathrooms. This continuous washing keeps the tile in good condition, but sometimes rust stains develop and these require special treatment. Mix one part sodium citrate in six parts of water and add an equal volume of glycerine. Make a thick paste with part of this solution and whiting, and apply to the rust spot and let dry. The process should be repeated till the spot disappears.

I might mention the treatment of two of the most frequent and stubborn stains we get on hospital floors —that is, ink and oil. Most of the difficulty is caused by the fact that the oil, or ink, is not wiped up as clean as possible as soon as it is spilled. It is most essential that ink and oil should not be left on the floor long enough to penetrate the wax coat and work into the pores of the floor itself. Oil can sometimes be removed by scrubbing with benzine or gasoline. If this is not successful, saturate a piece of white cotton batting with hydrogen peroxide and paste over the stain. Dip another piece in ammonia water and put over the first. Repeat until the stain disappears. Scouring with sandpaper will often remove ink, but if this is not effective more drastic treatment may be tried. One method is to touch the spot with a brush dipped in a few drops of nitric acid in a teaspoonful of water. Immediately the ink disappears rub the spot quickly with a wet cloth to remove all traces of the acid. Another plan is to use ½ oz. oxalic acid to ½ pint of warm water. Apply with a cloth and follow up with a warm water and vinegar solution (half and half) and wipe with a dry cloth.

SYNKAVITE
In Obstetrics

HEMORRHAGIC disorders in the newborn can be strikingly reduced by the administration of vitamin K to mothers during labour. Fitzgerald and Webster, J.A.M.A., 1942, **119:** 1082, reported that there was no evidence of neonatal bleeding in a series of 641 babies whose mothers had received vitamin K therapy. Synkavite, the Roche vitamin K-compound, is the choice of many physicians for routine prophylactic vitamin K therapy because of its all-round therapeutic efficiency. Molecule for molecule, it is one and one-half times as active as natural vitamin K, yet relatively non-toxic.

Oral tablets, 5 mgm., bottles of 40, 100, and 1,000.

Ampoules, 5 and 10 mgm., cartons of 6 and 100.

Literature and samples will be sent gladly on request.

HOFFMANN-LA ROCHE LIMITED

286 St. Paul Street, West **MONTREAL** **MONTREAL**

Makers of Medicines of Rare Quality

New Zealand

(Concluded from page 37)

been a source of difficulty to the government, the people and the doctors. Much contention might have been avoided had arrangements been completed with the doctors before promises were made regarding this service.

Specialists: No specialist service has been arranged as yet. To date all that the specialist can claim from the Fund, or the patient in the form of a refund, is the basic 7s 6d as in the case of the general practitioner.

Pharmaceutical benefits: The list of drugs which may be obtained free of charge has been steadily increased. The patient presents his prescription, the chemist fills it, the patient countersigns and the Fund pays.

X-ray: This service, when given in a public hospital, was added to the "free" list in 1941. With a private radiologist, the patient and the Social Security Fund divide the cost.

Physiotherapy: The arrangement for this service is comparable to that for x-ray with the additional factor that there is a great shortage of qualified personnel.

The Cost

New Zealand's social security benefits apply to every individual in the country, but those under 16 are not required to make payments to the Fund. Those over 16 are required to pay a registration fee: for women, 5s annually; for men, £1 annually. The major payment is a 5 per cent social security tax on all income. "It is a flat levy on everybody's income, including every company. All have to pay, and out of the fund the monetary benefits and health benefits mentioned are provided." As already stated, the hospital deficits are an additional charge on State and hospital district funds. The fact that we cannot have benefits without paying for them is reflected in the mounting tax rate of New Zealand. The Public Debt (excluding borrowing for war purposes) rose from £280,000,000 in 1935 to £342,000,000 in 1942. Taxation per head (also exclusive of war taxes) rose in the same period from £13-8-2 to £30-16-5.

Conclusion

In assessing any plan for the provision of health benefits, there are two fundamental questions that should be kept in mind:

(a) To what extent does the plan increase the availability of health services?

(b) To what extent does the plan tend to improve the quality of such health services?

The degree to which the answers to these questions are in the affirmative indicates the degree to which the ultimate goal of health legislation —the improvement of the health of the people—is being achieved. Is New Zealand's plan one for better service, or is it merely a different plan of paying for the same service? If there is no provision for increasing the supply of hospital beds and personnel—medical, dental and nursing—or of improving the quality of service, this would leave the government open to the valid criticism of a political move rather than a social consciousness.

Physicians Art Contest

(Concluded from page 62)

10 $1,000 War Bonds (E or F Series).

10 $500 War Bonds (E or F Series).

No physician may submit more than one piece nor win more than one of the 42 prizes. No physician is eligible for a prize unless he also submits for exhibition at either the 1945 or the 1946 annual exhibition of the A.P.A.A. at least one other original work (not previously exhibited at an A.P.A.A. Exhibition) in any medium, on any subject of his own choice.* Prizes will be awarded on a basis of conception and execution, irrespective of medium employed.

6. *Judges:* A competent board, now being selected, names to be announced.

7. *Expiration Date:*† Entries must be received at San Francisco not later than May 27th, 1946, for hanging at the time of the American Medical Association Annual Session, June, 1946, at San Francisco.

8. *Purpose of the Competition:* To memorialize the heroism and devotion of the medical profession in war and peace. All exhibitors (including prize-winners) shall retain ownership of their pieces. It is understood, however, that the A.P.A.A. shall have reproduction rights and also the privilege, for a period of three years after the close of the contest, of displaying prize-winning objects at art museums, libraries, county medical societies, medical schools, hospitals, and similar institutions for the purpose of enhancing the public's estimate of the medical profession. The Association shall also have the right to offer institutions such as those mentioned above, the privilege of copying any of the prize-winning objects for use as murals, cornerstones, friezes, architectural designs, etc.—for the purpose of memorializing the medical professions importance in war and peace.

N.B.—This special contest does not replace nor conflict with the regular American Physicians Art Association Annual Exhibitions, nor do these special prizes replace the regular A.P.A.A. prizes.

Further information can be obtained from Dr. F. H. Redewill, A.P.A.A. secretary, Flood Building, San Francisco, Cal., from the President, Dr. Max Thorek, 850 West Irving Park Boulevard, Chicago, from Mr. A. L. Rose, Evansville, Indiana, or from Dr. Harvey Agnew, who is one of the vice-presidents.

*Such other works would be eligible for the regular prizes of the American Physicians Art Association in accordance with the A.P.A.A. regular rules governing exhibitions.

†Subject to change if exigencies of war necessitate.

Alberta Government to Lend Funds to Construct Hospitals

The Government of Alberta has agreed to lend $105,000 to three east central Alberta municipal hospital districts. An entirely new hospital costing $50,000 will be built at Oyen. At Consort $35,000 will be spent on building a hospital and at Coronation $10,000 will buy the Coronation General Hospital from that town.

London Letter

(Concluded from page 60)

dary Commission with suitable safeguards for Ministerial and Parliamentary control. There is nothing particularly new in this proposal as we have had similar bodies before, so that there is no need for me to go into details which are not of any particular interest. Guidance will be given to the Commissioners on such points as the factors to be taken into consideration in determining areas. In these is included the important point that the interests of the country town and its surrounding countryside are not diverse but complementary and it is proposed to act on this principle, which involves a different approach to the subject than that which has been in operation in the past.

One matter has been definitely excluded from this White Paper and that is the position of London to which for the purposes of this consideration is attached the county of Middlesex. There will, however, I anticipate, be another opportunity before very long to return to that particular problem involving an area which, as I am well aware, is of interest to so many overseas.

INSTRUCTRESS WANTED

Science and practical arts instructor wanted for Victoria Hospital, Prince Albert, Saskatchewan, for September 1st, 1945. Salary $150.00 a month with full maintenance with four weeks vacation and four weeks sick time with pay each year. Apply to Mrs. J. S. Harry, Superintendent of Nurses, stating full particulars, age, qualifications, etc.

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Obstetrical Division of the Hamilton General Hospital (a Unit of 117 beds). Salary schedule in force. Candidates should be qualified to organize Clinical teaching of the Obstetrical Department. Apply to Box 139H, The Canadian Hospital, 57 Bloor St. W., Toronto 5, Ont.

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Lethbridge Mourns Loss of Pioneer and Hospital Founder

A resident of Lethbridge since 1909 and founder of the Van Haarlem Hospital, Mrs. Marie E. Van Haarlem died on February 8th at the age of 77 years. Herself a nurse, Mrs. Van Haarlem did a great deal in the early days of Lethbridge by founding the Van Haarlem Hospital some 35 years ago. Later this hospital formed the nucleus for the fine Saint Michael's Hospital. Always active, Mrs. Van Haarlem later became a school nurse. A movement is now underway to erect a memorial plaque to her memory.

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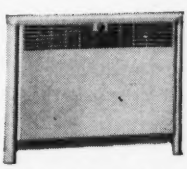

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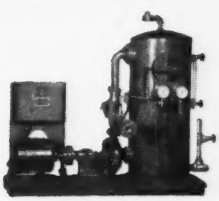

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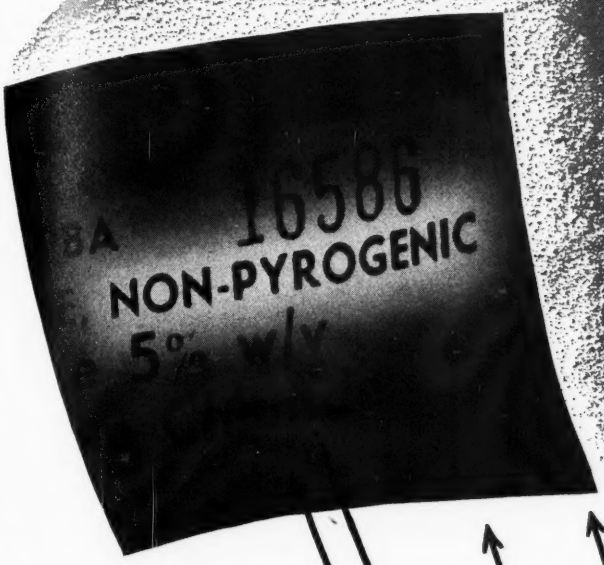

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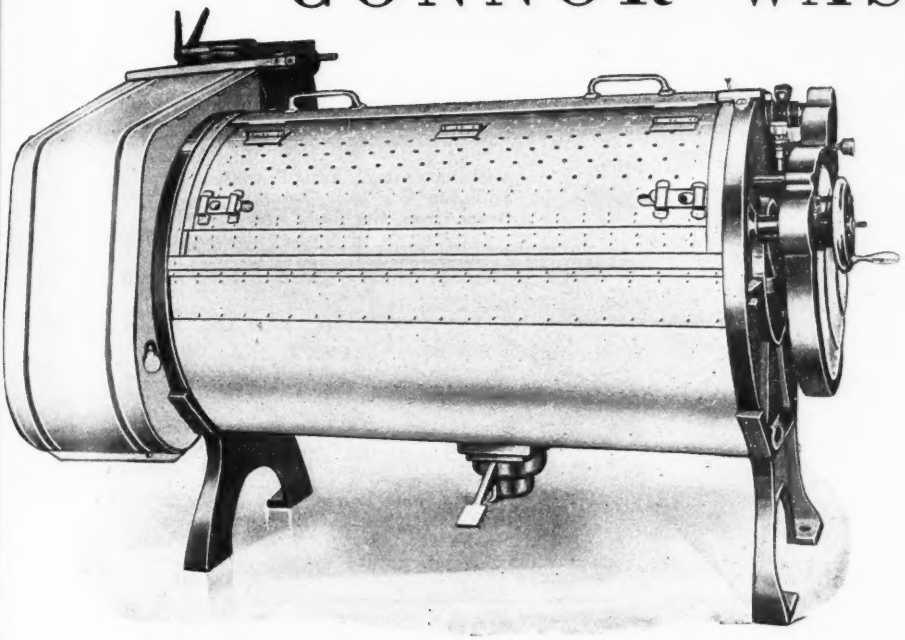

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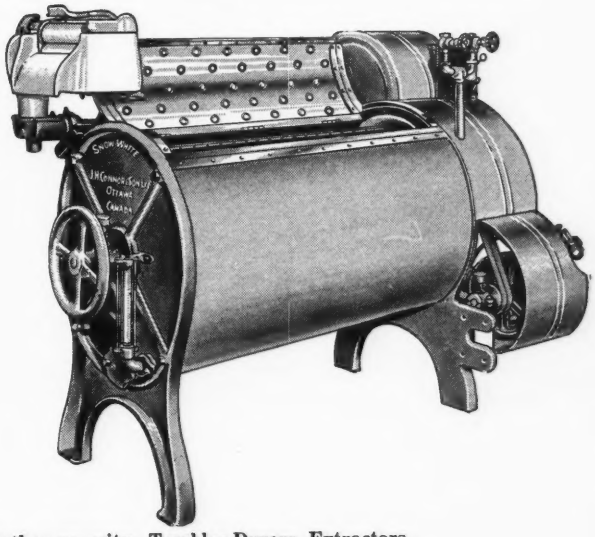

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(Report on Clinical Use of Bone Meal. Martin, E. M., Jour. C.M.A., Vol. 50).*

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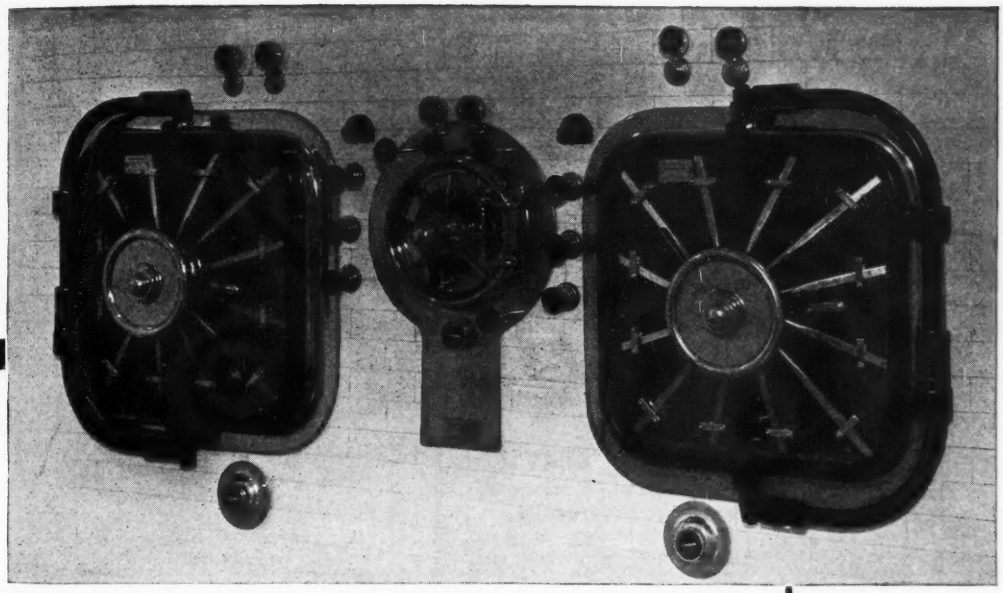

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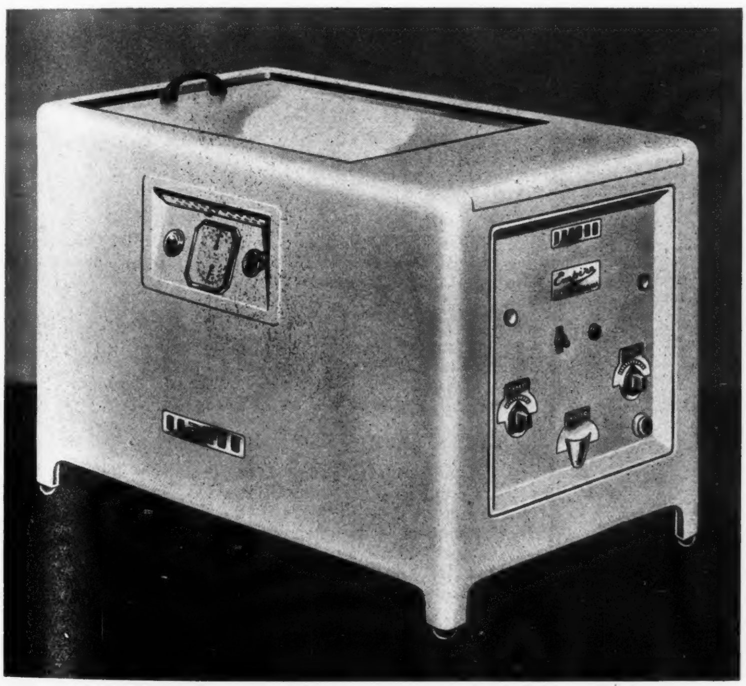

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